Care Act, they have health insurance, but thanks to community health centers, they have health care.

H.R. 2 also extends the CHIP program and keeps over 8 million low-income children and pregnant women in families from losing their health insurance.

Lastly, H.R. 2 finally fixes the SGR, the Medicare Sustainable Growth Rate. The SGR was an ill-conceived plan to control the growth in health care costs by slashing doctor pay. We were in danger of doctors dropping Medicare patients, putting seniors' access to critical medical care at risk. The yearly short-term fixes have cost us more over the years than it would have to get rid of it, so I am pleased we are finally doing the right thing today in a way that moves us toward quality health care for Americans.

Mr. Speaker, I'd like to take this opportunity to clarify a provision in H.R. 2 and how it differs from S. 178—the Senate Justice for Victims of Trafficking Act of 2015 (JVTA).

As you know, the Senate is having a debate about a provision to make the Hyde Amendment part of permanent law and to apply it to non-taxpayer funds. As co-chair of the Pro Choice Caucus, I want to make this clear: the Senate bill creates a new Domestic Trafficking Victims' Fund that would be funded—not by taxpayer dollars—but through fines imposed on defendants convicted of human trafficking, sexual exploitation and human smuggling crimes. The Hyde Amendment only applies to taxpayer dollars. Hyde Amendment restrictions have never been applied on a federal fund containing zero taxpayer dollars. This new fund is not federal dollars and therefore not eligible for Hyde. The pro-choice senators who are fighting against this expansion have my full support.

Mr. BURGESS. Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered.

The SPEAKER pro tempore. The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. BURGESS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 402, nays 12, answered ''present'' 5, not voting 13, as follows:

[Roll No. 143]

YEAS—402

Abraham
Adams
Aderholt
Aguilar
Allen
Amodei
Ashford
Babin
Barletta
Barr
Barton
Bass
Beatty
Becerra
Benishek
Bera
Beyer
Bilirakis
Bishop (GA)
Bishop (MI)
Bishop (UT)
Black
Blackburn
Blum
Blumenauer
Bonamici
Bost
Boustany
Boyle, Brendan F.
Brady (PA)
Brady (TX)
Brat
Bridenstine
Brooks (IN)
Brown (FL)
Brownley (CA)
Buchanan
Buck
Bucshon
Burgess
Bustos
Butterfield
Byrne
Calvert
Capps
Capuano
Cárdenas
Carney
Carson (IN)
Carter (GA)
Carter (TX)
Cartwright
Castor (FL)
Castro (TX)
Chabot
Chaffetz
Chu, Judy
Clark (MA)
Clarke (NY)
Clawson (FL)
Clay
Cleaver
Clyburn
Coffman
Cohen
Cole
Collins (GA)
Collins (NY)
Comstock
Conaway
Connolly
Cook
Costa
Costello (PA)
Courtney
Cramer
Crawford
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Curbelo (FL)
Davis (CA)
Davis, Danny
Davis, Rodney
DeFazio
DeGette
Delaney
DeLauro
DelBene
Denham
Dent
DeSantis
DeSaulnier
DesJarlais
Deutch
Diaz-Balart
Dingell
Doggett
Dold
Doyle, Michael F.
Duckworth
Duffy
Duncan (SC)
Duncan (TN)
Edwards
Ellison
Ellmers (NC)
Emmer (MN)
Engel
Eshoo
Esty
Farenthold
Farr
Fattah
Fincher
Fitzpatrick
Fleischmann
Fleming
Flores
Forbes
Fortenberry
Foster
Foxx
Frankel (FL)
Frelinghuysen
Fudge
Gabbard
Garamendi
Garrett
Gibbs
Gibson
Gohmert
Goodlatte
Gowdy
Granger
Graves (GA)
Graves (LA)
Graves (MO)
Grayson
Green, Al
Green, Gene
Grijalva
Grothman
Guinta
Guthrie
Gutiérrez
Hahn
Hanna
Hardy
Harper
Harris
Hartzler
Hastings
Heck (NV)
Heck (WA)
Hensarling
Herrera Beutler
Hice, Jody B.
Higgins
Hill
Himes
Holding
Honda
Hoyer
Hudson
Huffman
Huizenga (MI)
Hultgren
Hunter
Hurd (TX)
Hurt (VA)
Israel
Issa
Jackson Lee
Jenkins (KS)
Jenkins (WV)
Johnson (OH)
Johnson, E. B.
Johnson, Sam
Jolly
Jordan
Joyce
Kaptur
Katko
Keating
Kelly (IL)
Kelly (PA)
Kennedy
Kildee
Kilmer
Kind
King (IA)
King (NY)
Kinzinger (IL)
Kirkpatrick
Kline
Knight
Kuster
LaMalfa
Lamborn
Lance
Larsen (WA)
Larson (CT)
Latta
Lawrence
Lee
Levin
Lewis
Lieu, Ted
Lipinski
LoBiondo
Loebsack
Lofgren
Long
Loudermilk
Love
Lowenthal
Lowey
Lucas
Luetkemeyer
Lujan Grisham (NM)
Luján, Ben Ray (NM)
Lummis
Lynch
MacArthur
Maloney, Carolyn
Maloney, Sean
Marchant
Marino
Matsui
McCarthy
McCaul
McClintock
McCollum
McDermott
McGovern
McHenry
McKinley
McMorris Rodgers
McNerney
McSally
Meadows
Meehan
Meng
Messer
Mica
Miller (FL)
Miller (MI)
Moolenaar
Mooney (WV)
Moore
Moulton
Mullin
Murphy (FL)
Murphy (PA)
Nadler
Napolitano
Neal
Neugebauer
Newhouse
Noem
Nolan
Norcross
Nugent
Nunes
O'Rourke
Olson
Pallone
Palmer
Pascrell
Paulsen
Pearce
Pelosi
Perlmutter
Perry
Peters
Peterson
Pingree
Pittenger
Pitts
Pocan
Poe (TX)
Poliquin
Polis
Pompeo
Posey
Price (NC)
Price, Tom
Quigley
Ratcliffe
Reed
Reichert
Renacci
Ribble
Rice (NY)
Rice (SC)
Richmond
Rigell
Roby
Roe (TN)
Rogers (AL)
Rogers (KY)
Rohrabacher
Rokita
Rooney (FL)
Ros-Lehtinen
Roskam
Ross
Rothfus
Rouzer
Roybal-Allard
Royce
Ruppersberger
Rush
Russell
Ryan (OH)
Ryan (WI)
Salmon
Sánchez, Linda T.
Sanchez, Loretta
Sanford
Sarbanes
Scalise
Schakowsky
Schiff
Schock
Schrader
Scott (VA)
Scott, Austin
Scott, David
Sensenbrenner
Serrano
Sessions
Sewell (AL)
Sherman
Shimkus
Shuster
Simpson
Sinema
Sires
Slaughter
Smith (MO)
Smith (NE)
Smith (NJ)
Smith (TX)
Speier
Stefanik
Stewart
Stivers
Swalwell (CA)
Takai
Takano
Thompson (CA)
Thompson (MS)
Thompson (PA)
Thornberry
Tiberi
Tipton
Titus
Torres
Trott
Turner
Upton
Valadao
Van Hollen
Vargas
Veasey
Vela
Velázquez
Visclosky
Wagner
Walberg
Walden
Walker
Walorski
Walters, Mimi
Walz
Wasserman Schultz
Waters, Maxine
Watson Coleman
Weber (TX)
Webster (FL)
Welch
Wenstrup
Westerman
Westmoreland
Whitfield
Williams
Wilson (FL)
Wilson (SC)
Wittman
Womack
Woodall
Yarmuth
Yoder
Yoho
Young (IA)
Young (IN)
Zeldin
Zinke

NAYS—12

Amash
Brooks (AL)
Cicilline
Cooper
Gallego
Graham
Huelskamp
Jones
Massie
Rangel
Tonko
Tsongas

ANSWERED ''PRESENT''—5

Gosar
Griffith
Labrador
Mulvaney
Stutzman

NOT VOTING—13

Conyers
Franks (AZ)
Hinojosa
Jeffries
Johnson (GA)
Langevin
Meeks
Palazzo
Payne
Ruiz
Schweikert
Smith (WA)
Young (AK)

□ 1011

Mr. AMASH changed his vote from ''yea'' to ''nay.''

Messrs. BISHOP of Georgia, WALZ, LOEBSACK, MCNERNEY, CAPUANO, O'ROURKE, HANNA, and SEAN PATRICK MALONEY of New York changed their vote from ''nay'' to ''yea.''

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. CONYERS. Mr. Speaker, I was not present for rollcall vote No. 143. Had I been present, I would have voted "aye."

Ms. TSONGAS. Mr. Speaker, on rollcall vote No. 143, I voted "no" and I intended to vote "yes."

MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015

Mr. PITTS. Mr. Speaker, pursuant to House Resolution 173, I call up the bill (H.R. 2) to amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and strengthen Medicare access by improving physician payments and making other improvements, to reauthorize the Children's Health Insurance Program, and for other purposes, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. POE of Texas). Pursuant to House Resolution 173, the amendment printed in House Report 114–50 is considered adopted. The bill, as amended, is considered read.

The text of the bill, as amended, is as follows:

H.R. 2

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Access and CHIP Reauthorization Act of 2015''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION

SEC. 101. REPEALING THE SUSTAINABLE GROWTH RATE (SGR) AND IMPROVING MEDICARE PAYMENT FOR PHYSICIANS' SERVICES.

(a) STABILIZING FEE UPDATES.—

(1) REPEAL OF SGR PAYMENT METHODOLOGY.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(A) in subsection (d)—

(i) in paragraph (1)(A)—

(I) by inserting ''and ending with 2025'' after ''beginning with 2001''; and

(II) by inserting ''or a subsequent paragraph'' after ''paragraph (4)''; and

(ii) in paragraph (4)—

(I) in the heading, by inserting ''AND ENDING WITH 2014'' after ''YEARS BEGINNING WITH 2001''; and

(II) in subparagraph (A), by inserting ''and ending with 2014'' after ''a year beginning with 2001''; and

(B) in subsection (f)—

(i) in paragraph (1)(B), by inserting ''through 2014'' after ''of each succeeding year''; and

(ii) in paragraph (2), in the matter preceding subparagraph (A), by inserting ''and ending with 2014'' after ''beginning with 2000''.

(2) UPDATE OF RATES FOR 2015 AND SUBSEQUENT YEARS.—Subsection (d) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(A) in paragraph (1)(A), by adding at the end the following: ''There shall be two separate conversion factors for each year beginning with 2026, one for items and services furnished by a qualifying APM participant (as defined in section 1833(z)(2)) (referred to in this subsection as the 'qualifying APM conversion factor') and the other for other items and services (referred to in this subsection as the 'nonqualifying APM conversion factor'), equal to the respective conversion factor for the previous year (or, in the case of 2026, equal to the single conversion factor for 2025) multiplied by the update established under paragraph (20) for such respective conversion factor for such year.'';

(B) in paragraph (1)(D), by inserting ''(or, beginning with 2026, applicable conversion factor)'' after ''single conversion factor''; and

(C) by striking paragraph (16) and inserting the following new paragraphs:

''(16) UPDATE FOR JANUARY THROUGH JUNE OF 2015.—Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), (13)(B), (14)(B), and (15)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2015 for the period beginning on January 1, 2015, and ending on June 30, 2015, the update to the single conversion factor shall be 0.0 percent.

''(17) UPDATE FOR JULY THROUGH DECEMBER OF 2015.—The update to the single conversion factor established in paragraph (1)(C) for the period beginning on July 1, 2015, and ending on December 31, 2015, shall be 0.5 percent.

''(18) UPDATE FOR 2016 THROUGH 2019.—The update to the single conversion factor established in paragraph (1)(C) for 2016 and each subsequent year through 2019 shall be 0.5 percent.

''(19) UPDATE FOR 2020 THROUGH 2025.—The update to the single conversion factor established in paragraph (1)(C) for 2020 and each subsequent year through 2025 shall be 0.0 percent.

''(20) UPDATE FOR 2026 AND SUBSEQUENT YEARS.—For 2026 and each subsequent year, the update to the qualifying APM conversion factor established under paragraph (1)(A) is 0.75 percent, and the update to the nonqualifying APM conversion factor established under such paragraph is 0.25 percent.''.

(3) MEDPAC REPORTS.—

(A) INITIAL REPORT.—Not later than July 1, 2017, the Medicare Payment Advisory Commission shall submit to Congress a report on the relationship between—

(i) physician and other health professional utilization and expenditures (and the rate of increase of such utilization and expenditures) of items and services for which payment is made under section 1848 of the Social Security Act (42 U.S.C. 1395w–4); and

(ii) total utilization and expenditures (and the rate of increase of such utilization and expenditures) under parts A, B, and D of title XVIII of such Act.

Such report shall include a methodology to describe such relationship and the impact of changes in such physician and other health professional practice and service ordering patterns on total utilization and expenditures under parts A, B, and D of such title.

(B) FINAL REPORT.—Not later than July 1, 2021, the Medicare Payment Advisory Commission shall submit to Congress a report on the relationship described in subparagraph (A), including the results determined from applying the methodology included in the report submitted under such subparagraph.

(C) REPORT ON UPDATE TO PHYSICIANS' SERVICES UNDER MEDICARE.—Not later than July 1, 2019, the Medicare Payment Advisory Commission shall submit to Congress a report on—

(i) the payment update for professional services applied under the Medicare program under title XVIII of the Social Security Act for the period of years 2015 through 2019;

(ii) the effect of such update on the efficiency, economy, and quality of care provided under such program;

(iii) the effect of such update on ensuring a sufficient number of providers to maintain access to care by Medicare beneficiaries; and

(iv) recommendations for any future payment updates for professional services under such program to ensure adequate access to care is maintained for Medicare beneficiaries.

(b) CONSOLIDATION OF CERTAIN CURRENT LAW PERFORMANCE PROGRAMS WITH NEW MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

(1) EHR MEANINGFUL USE INCENTIVE PROGRAM.—

(A) SUNSETTING SEPARATE MEANINGFUL USE PAYMENT ADJUSTMENTS.—Section 1848(a)(7)(A) of the Social Security Act (42 U.S.C. 1395w–4(a)(7)(A)) is amended—

(i) in clause (i), by striking ''2015 or any subsequent payment year'' and inserting ''each of 2015 through 2018'';

(ii) in clause (ii)(III), by striking ''each subsequent year'' and inserting ''2018''; and

(iii) in clause (iii)—

(I) in the heading, by striking ''AND SUBSEQUENT YEARS'';

(II) by striking ''and each subsequent year''; and

(III) by striking '', but in no case shall the applicable percent be less than 95 percent''.

(B) CONTINUATION OF MEANINGFUL USE DETERMINATIONS FOR MIPS.—Section 1848(o)(2) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)) is amended—

(i) in subparagraph (A), in the matter preceding clause (i)—

(I) by striking ''For purposes of paragraph (1), an'' and inserting ''An''; and

(II) by inserting '', or pursuant to subparagraph (D) for purposes of subsection (q), for a performance period under such subsection for a year'' after ''under such subsection for a year''; and

(ii) by adding at the end the following new subparagraph:

''(D) CONTINUED APPLICATION FOR PURPOSES OF MIPS.—With respect to 2019 and each subsequent payment year, the Secretary shall, for purposes of subsection (q) and in accordance with paragraph (1)(F) of such subsection, determine whether an eligible professional who is a MIPS eligible professional (as defined in subsection (q)(1)(C)) for such year is a meaningful EHR user under this paragraph for the performance period under subsection (q) for such year.''.

(2) QUALITY REPORTING.—

(A) SUNSETTING SEPARATE QUALITY REPORTING INCENTIVES.—Section 1848(a)(8)(A) of the Social Security Act (42 U.S.C. 1395w–4(a)(8)(A)) is amended—

(i) in clause (i), by striking ''2015 or any subsequent year'' and inserting ''each of 2015 through 2018''; and

(ii) in clause (ii)(II), by striking ''and each subsequent year'' and inserting '', 2017, and 2018''.

(B) CONTINUATION OF QUALITY MEASURES AND PROCESSES FOR MIPS.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(i) in subsection (k), by adding at the end the following new paragraph:

''(9) CONTINUED APPLICATION FOR PURPOSES OF MIPS AND FOR CERTAIN PROFESSIONALS VOLUNTEERING TO REPORT.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out the provisions of this subsection—

''(A) for purposes of subsection (q); and

''(B) for eligible professionals who are not MIPS eligible professionals (as defined in subsection (q)(1)(C)) for the year involved.''; and

(ii) in subsection (m)—

(I) by redesignating paragraph (7) added by section 10327(a) of Public Law 111–148 as paragraph (8); and

(II) by adding at the end the following new paragraph:

''(9) CONTINUED APPLICATION FOR PURPOSES OF MIPS AND FOR CERTAIN PROFESSIONALS VOLUNTEERING TO REPORT.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out the processes under this subsection—

''(A) for purposes of subsection (q); and

''(B) for eligible professionals who are not MIPS eligible professionals (as defined in subsection (q)(1)(C)) for the year involved.''.

(3) VALUE-BASED PAYMENTS.—

(A) SUNSETTING SEPARATE VALUE-BASED PAYMENTS.—Clause (iii) of section 1848(p)(4)(B) of the Social Security Act (42 U.S.C. 1395w–4(p)(4)(B)) is amended to read as follows:

''(iii) APPLICATION.—The Secretary shall apply the payment modifier established under this subsection for items and services furnished on or after January 1, 2015, with respect to specific physicians and groups of physicians the Secretary determines appropriate, and for services furnished on or after January 1, 2017, with respect to all physicians and groups of physicians. Such payment modifier shall not be applied for items and services furnished on or after January 1, 2019.''.

(B) CONTINUATION OF VALUE-BASED PAYMENT MODIFIER MEASURES FOR MIPS.—Section 1848(p) of the Social Security Act (42 U.S.C. 1395w–4(p)) is amended—

(i) in paragraph (2), by adding at the end the following new subparagraph:

''(C) CONTINUED APPLICATION FOR PURPOSES OF MIPS.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out subparagraph (B) for purposes of subsection (q).''; and

(ii) in paragraph (3), by adding at the end the following: ''With respect to 2019 and each subsequent year, the Secretary shall, in accordance with subsection (q)(1)(F), carry out this paragraph for purposes of subsection (q).''.

(c) MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

(1) IN GENERAL.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new subsection:

''(q) MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish an eligible professional Merit-based Incentive Payment System (in this subsection referred to as the 'MIPS') under which the Secretary shall—

''(i) develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards under paragraph (3) for a performance period (as established under paragraph (4)) for a year;

''(ii) using such methodology, provide for a composite performance score in accordance with paragraph (5) for each such professional for each performance period; and

''(iii) use such composite performance score of the MIPS eligible professional for a performance period for a year to determine and apply a MIPS adjustment factor (and, as applicable, an additional MIPS adjustment factor) under paragraph (6) to the professional for the year.

Notwithstanding subparagraph (C)(ii), under the MIPS, the Secretary shall permit any eligible professional (as defined in subsection (k)(3)(B)) to report on applicable measures and activities described in paragraph (2)(B).

''(B) PROGRAM IMPLEMENTATION.—The MIPS shall apply to payments for items and services furnished on or after January 1, 2019.

''(C) MIPS ELIGIBLE PROFESSIONAL DEFINED.—

''(i) IN GENERAL.—For purposes of this subsection, subject to clauses (ii) and (iv), the term 'MIPS eligible professional' means—

''(I) for the first and second years for which the MIPS applies to payments (and for the performance period for such first and second year), a physician (as defined in section 1861(r)), a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5)), a certified registered nurse anesthetist (as defined in section 1861(bb)(2)), and a group that includes such professionals; and

''(II) for the third year for which the MIPS applies to payments (and for the performance period for such third year) and for each succeeding year (and for the performance period for each such year), the professionals described in subclause (I), such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary, and a group that includes such professionals.

''(ii) EXCLUSIONS.—For purposes of clause (i), the term 'MIPS eligible professional' does not include, with respect to a year, an eligible professional (as defined in subsection (k)(3)(B)) who—

''(I) is a qualifying APM participant (as defined in section 1833(z)(2));

''(II) subject to clause (vii), is a partial qualifying APM participant (as defined in clause (iii)) for the most recent period for which data are available and who, for the performance period with respect to such year, does not report on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a professional under the MIPS; or

''(III) for the performance period with respect to such year, does not exceed the low-

volume threshold measurement selected under clause (iv).

''(iii) PARTIAL QUALIFYING APM PARTICIPANT.—For purposes of this subparagraph, the term 'partial qualifying APM participant' means, with respect to a year, an eligible professional for whom the Secretary determines the minimum payment percentage (or percentages), as applicable, described in paragraph (2) of section 1833(z) for such year have not been satisfied, but who would be considered a qualifying APM participant (as defined in such paragraph) for such year if—

''(I) with respect to 2019 and 2020, the reference in subparagraph (A) of such paragraph to 25 percent was instead a reference to 20 percent;

''(II) with respect to 2021 and 2022—

''(aa) the reference in subparagraph (B)(i) of such paragraph to 50 percent was instead a reference to 40 percent; and

''(bb) the references in subparagraph (B)(ii) of such paragraph to 50 percent and 25 percent of such paragraph were instead references to 40 percent and 20 percent, respectively; and

''(III) with respect to 2023 and subsequent years—

''(aa) the reference in subparagraph (C)(i) of such paragraph to 75 percent was instead a reference to 50 percent; and

''(bb) the references in subparagraph (C)(ii) of such paragraph to 75 percent and 25 percent of such paragraph were instead references to 50 percent and 20 percent, respectively.

''(iv) SELECTION OF LOW-VOLUME THRESHOLD MEASUREMENT.—The Secretary shall select a low-volume threshold to apply for purposes of clause (ii)(III), which may include one or more or a combination of the following:

''(I) The minimum number (as determined by the Secretary) of individuals enrolled under this part who are treated by the eligible professional for the performance period involved.

''(II) The minimum number (as determined by the Secretary) of items and services furnished to individuals enrolled under this part by such professional for such performance period.

''(III) The minimum amount (as determined by the Secretary) of allowed charges billed by such professional under this part for such performance period.

''(v) TREATMENT OF NEW MEDICARE ENROLLED ELIGIBLE PROFESSIONALS.—In the case of a professional who first becomes a Medicare enrolled eligible professional during the performance period for a year (and had not previously submitted claims under this title such as a person, an entity, or a part of a physician group or under a different billing number or tax identifier), such professional shall not be treated under this subsection as a MIPS eligible professional until the subsequent year and performance period for such subsequent year.

''(vi) CLARIFICATION.—In the case of items and services furnished during a year by an individual who is not a MIPS eligible professional (including pursuant to clauses (ii) and (v)) with respect to a year, in no case shall a MIPS adjustment factor (or additional MIPS adjustment factor) under paragraph (6) apply to such individual for such year.

''(vii) PARTIAL QUALIFYING APM PARTICIPANT CLARIFICATIONS.—

''(I) TREATMENT AS MIPS ELIGIBLE PROFESSIONAL.—In the case of an eligible professional who is a partial qualifying APM participant, with respect to a year, and who, for the performance period for such year, reports on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a professional under the MIPS, such eligible professional is considered to be a MIPS eligible professional with respect to such year.

''(II) NOT ELIGIBLE FOR QUALIFYING APM PARTICIPANT PAYMENTS.—In no case shall an eligible professional who is a partial qualifying APM participant, with respect to a year, be considered a qualifying APM participant (as defined in paragraph (2) of section 1833(z)) for such year or be eligible for the additional payment under paragraph (1) of such section for such year.

''(D) APPLICATION TO GROUP PRACTICES.—

''(i) IN GENERAL.—Under the MIPS:

''(I) QUALITY PERFORMANCE CATEGORY.—The Secretary shall establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for MIPS eligible professionals in a group practice with respect to assessing performance of such group with respect to the performance category described in clause (i) of paragraph (2)(A).

''(II) OTHER PERFORMANCE CATEGORIES.—The Secretary may establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for MIPS eligible professionals in a group practice with respect to assessing the performance of such group with respect to the performance categories described in clauses (ii) through (iv) of such paragraph.

''(ii) ENSURING COMPREHENSIVENESS OF GROUP PRACTICE ASSESSMENT.—The process established under clause (i) shall to the extent practicable reflect the range of items and services furnished by the MIPS eligible professionals in the group practice involved.

''(E) USE OF REGISTRIES.—Under the MIPS, the Secretary shall encourage the use of qualified clinical data registries pursuant to subsection (m)(3)(E) in carrying out this subsection.

''(F) APPLICATION OF CERTAIN PROVISIONS.—In applying a provision of subsection (k), (m), (o), or (p) for purposes of this subsection, the Secretary shall—

''(i) adjust the application of such provision to ensure the provision is consistent with the provisions of this subsection; and

''(ii) not apply such provision to the extent that the provision is duplicative with a provision of this subsection.

''(G) ACCOUNTING FOR RISK FACTORS.—

''(i) RISK FACTORS.—Taking into account the relevant studies conducted and recommendations made in reports under section 2(d) of the Improving Medicare Post-Acute Care Transformation Act of 2014, and, as appropriate, other information, including information collected before completion of such studies and recommendations, the Secretary, on an ongoing basis, shall, as the Secretary determines appropriate and based on an individual's health status and other risk factors—

''(I) assess appropriate adjustments to quality measures, resource use measures, and other measures used under the MIPS; and

''(II) assess and implement appropriate adjustments to payment adjustments, composite performance scores, scores for performance categories, or scores for measures or activities under the MIPS.

''(2) MEASURES AND ACTIVITIES UNDER PERFORMANCE CATEGORIES.—

''(A) PERFORMANCE CATEGORIES.—Under the MIPS, the Secretary shall use the following performance categories (each of which is referred to in this subsection as a performance category) in determining the composite performance score under paragraph (5):

''(i) Quality.

''(ii) Resource use.

''(iii) Clinical practice improvement activities.

''(iv) Meaningful use of certified EHR technology.

''(B) MEASURES AND ACTIVITIES SPECIFIED FOR EACH CATEGORY.—For purposes of paragraph (3)(A) and subject to subparagraph (C), measures and activities specified for a performance period (as established under paragraph (4)) for a year are as follows:

''(i) QUALITY.—For the performance category described in subparagraph (A)(i), the quality measures included in the final measures list published under subparagraph (D)(i) for such year and the list of quality measures described in subparagraph (D)(vi) used by qualified clinical data registries under subsection (m)(3)(E).

''(ii) RESOURCE USE.—For the performance category described in subparagraph (A)(ii), the measurement of resource use for such period under subsection (p)(3), using the methodology under subsection (r) as appropriate, and, as feasible and applicable, accounting for the cost of drugs under part D.

''(iii) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—For the performance category described in subparagraph (A)(iii), clinical practice improvement activities (as defined in subparagraph (C)(v)(III)) under subcategories specified by the Secretary for such period, which shall include at least the following:

''(I) The subcategory of expanded practice access, such as same day appointments for urgent needs and after hours access to clinician advice.

''(II) The subcategory of population management, such as monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry.

''(III) The subcategory of care coordination, such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth.

''(IV) The subcategory of beneficiary engagement, such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision-making mechanisms.

''(V) The subcategory of patient safety and practice assessment, such as through use of clinical or surgical checklists and practice assessments related to maintaining certification.

''(VI) The subcategory of participation in an alternative payment model (as defined in section 1833(z)(3)(C)).

In establishing activities under this clause, the Secretary shall give consideration to the circumstances of small practices (consisting of 15 or fewer professionals) and practices located in rural areas and in health professional shortage areas (as designated under section 332(a)(1)(A) of the Public Health Service Act).

''(iv) MEANINGFUL EHR USE.—For the performance category described in subparagraph (A)(iv), the requirements established for such period under subsection (o)(2) for determining whether an eligible professional is a meaningful EHR user.

''(C) ADDITIONAL PROVISIONS.—

''(i) EMPHASIZING OUTCOME MEASURES UNDER THE QUALITY PERFORMANCE CATEGORY.—In applying subparagraph (B)(i), the Secretary shall, as feasible, emphasize the application of outcome measures.

''(ii) APPLICATION OF ADDITIONAL SYSTEM MEASURES.—The Secretary may use measures used for a payment system other than for physicians, such as measures for inpatient hospitals, for purposes of the performance categories described in clauses (i) and (ii) of subparagraph (A). For purposes of the previous sentence, the Secretary may not

use measures for hospital outpatient departments, except in the case of items and services furnished by emergency physicians, radiologists, and anesthesiologists.

''(iii) GLOBAL AND POPULATION-BASED MEASURES.—The Secretary may use global measures, such as global outcome measures, and population-based measures for purposes of the performance category described in subparagraph (A)(i).

''(iv) APPLICATION OF MEASURES AND ACTIVITIES TO NON-PATIENT-FACING PROFESSIONALS.—In carrying out this paragraph, with respect to measures and activities specified in subparagraph (B) for performance categories described in subparagraph (A), the Secretary—

''(I) shall give consideration to the circumstances of professional types (or subcategories of those types determined by practice characteristics) who typically furnish services that do not involve face-to-face interaction with a patient; and

''(II) may, to the extent feasible and appropriate, take into account such circumstances and apply under this subsection with respect to MIPS eligible professionals of such professional types or subcategories, alternative measures or activities that fulfill the goals of the applicable performance category.

In carrying out the previous sentence, the Secretary shall consult with professionals of such professional types or subcategories.

''(v) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—

''(I) REQUEST FOR INFORMATION.—In initially applying subparagraph (B)(iii), the Secretary shall use a request for information to solicit recommendations from stakeholders to identify activities described in such subparagraph and specifying criteria for such activities.

''(II) CONTRACT AUTHORITY FOR CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY.—In applying subparagraph (B)(iii), the Secretary may contract with entities to assist the Secretary in—

''(aa) identifying activities described in subparagraph (B)(iii);

''(bb) specifying criteria for such activities; and

''(cc) determining whether a MIPS eligible professional meets such criteria.

''(III) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES DEFINED.—For purposes of this subsection, the term 'clinical practice improvement activity' means an activity that relevant eligible professional organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.

''(D) ANNUAL LIST OF QUALITY MEASURES AVAILABLE FOR MIPS ASSESSMENT.—

''(i) IN GENERAL.—Under the MIPS, the Secretary, through notice and comment rulemaking and subject to the succeeding clauses of this subparagraph, shall, with respect to the performance period for a year, establish an annual final list of quality measures from which MIPS eligible professionals may choose for purposes of assessment under this subsection for such performance period. Pursuant to the previous sentence, the Secretary shall—

''(I) not later than November 1 of the year prior to the first day of the first performance period under the MIPS, establish and publish in the Federal Register a final list of quality measures; and

''(II) not later than November 1 of the year prior to the first day of each subsequent performance period, update the final list of quality measures from the previous year (and publish such updated final list in the Federal Register), by—

''(aa) removing from such list, as appropriate, quality measures, which may include the removal of measures that are no longer meaningful (such as measures that are topped out);

''(bb) adding to such list, as appropriate, new quality measures; and

''(cc) determining whether or not quality measures on such list that have undergone substantive changes should be included in the updated list.

''(ii) CALL FOR QUALITY MEASURES.—

''(I) IN GENERAL.—Eligible professional organizations and other relevant stakeholders shall be requested to identify and submit quality measures to be considered for selection under this subparagraph in the annual list of quality measures published under clause (i) and to identify and submit updates to the measures on such list. For purposes of the previous sentence, measures may be submitted regardless of whether such measures were previously published in a proposed rule or endorsed by an entity with a contract under section 1890(a).

''(II) ELIGIBLE PROFESSIONAL ORGANIZATION DEFINED.—In this subparagraph, the term 'eligible professional organization' means a professional organization as defined by nationally recognized specialty boards of certification or equivalent certification boards.

''(iii) REQUIREMENTS.—In selecting quality measures for inclusion in the annual final list under clause (i), the Secretary shall—

''(I) provide that, to the extent practicable, all quality domains (as defined in subsection (s)(1)(B)) are addressed by such measures; and

''(II) ensure that such selection is consistent with the process for selection of measures under subsections (k), (m), and (p)(2).

''(iv) PEER REVIEW.—Before including a new measure in the final list of measures published under clause (i) for a year, the Secretary shall submit for publication in applicable specialty-appropriate, peer-reviewed journals such measure and the method for developing and selecting such measure, including clinical and other data supporting such measure.

''(v) MEASURES FOR INCLUSION.—The final list of quality measures published under clause (i) shall include, as applicable, measures under subsections (k), (m), and (p)(2), including quality measures from among—

''(I) measures endorsed by a consensus-based entity;

''(II) measures developed under subsection (s); and

''(III) measures submitted under clause (ii)(I).

Any measure selected for inclusion in such list that is not endorsed by a consensus-based entity shall have a focus that is evidence-based.

''(vi) EXCEPTION FOR QUALIFIED CLINICAL DATA REGISTRY MEASURES.—Measures used by a qualified clinical data registry under subsection (m)(3)(E) shall not be subject to the requirements under clauses (i), (iv), and (v). The Secretary shall publish the list of measures used by such qualified clinical data registries on the Internet website of the Centers for Medicare & Medicaid Services.

''(vii) EXCEPTION FOR EXISTING QUALITY MEASURES.—Any quality measure specified by the Secretary under subsection (k) or (m), including under subsection (m)(3)(E), and any measure of quality of care established under subsection (p)(2) for the reporting period or performance period under the respective subsection beginning before the first performance period under the MIPS—

''(I) shall not be subject to the requirements under clause (i) (except under items (aa) and (cc) of subclause (II) of such clause) or to the requirement under clause (iv); and

''(II) shall be included in the final list of quality measures published under clause (i) unless removed under clause (i)(II)(aa).

''(viii) CONSULTATION WITH RELEVANT ELIGIBLE PROFESSIONAL ORGANIZATIONS AND OTHER RELEVANT STAKEHOLDERS.—Relevant eligible professional organizations and other relevant stakeholders, including State and national medical societies, shall be consulted in carrying out this subparagraph.

''(ix) OPTIONAL APPLICATION.—The process under section 1890A is not required to apply to the selection of measures under this subparagraph.

''(3) PERFORMANCE STANDARDS.—

''(A) ESTABLISHMENT.—Under the MIPS, the Secretary shall establish performance standards with respect to measures and activities specified under paragraph (2)(B) for a performance period (as established under paragraph (4)) for a year.

''(B) CONSIDERATIONS IN ESTABLISHING STANDARDS.—In establishing such performance standards with respect to measures and activities specified under paragraph (2)(B), the Secretary shall consider the following:

''(i) Historical performance standards.

''(ii) Improvement.

''(iii) The opportunity for continued improvement.

''(4) PERFORMANCE PERIOD.—The Secretary shall establish a performance period (or periods) for a year (beginning with 2019). Such performance period (or periods) shall begin and end prior to the beginning of such year and be as close as possible to such year. In this subsection, such performance period (or periods) for a year shall be referred to as the performance period for the year.

''(5) COMPOSITE PERFORMANCE SCORE.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and taking into account, as available and applicable, paragraph (1)(G), the Secretary shall develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards under paragraph (3) with respect to applicable measures and activities specified in paragraph (2)(B) with respect to each performance category applicable to such professional for a performance period (as established under paragraph (4)) for a year. Using such methodology, the Secretary shall provide for a composite assessment (using a scoring scale of 0 to 100) for each such professional for the performance period for such year. In this subsection such a composite assessment for such a professional with respect to a performance period shall be referred to as the 'composite performance score' for such professional for such performance period.

''(B) INCENTIVE TO REPORT; ENCOURAGING USE OF CERTIFIED EHR TECHNOLOGY FOR REPORTING QUALITY MEASURES.—

''(i) INCENTIVE TO REPORT.—Under the methodology established under subparagraph (A), the Secretary shall provide that in the case of a MIPS eligible professional who fails to report on an applicable measure or activity that is required to be reported by the professional, the professional shall be treated as achieving the lowest potential score applicable to such measure or activity.

''(ii) ENCOURAGING USE OF CERTIFIED EHR TECHNOLOGY AND QUALIFIED CLINICAL DATA REGISTRIES FOR REPORTING QUALITY MEASURES.—Under the methodology established under subparagraph (A), the Secretary shall—

''(I) encourage MIPS eligible professionals to report on applicable measures with respect to the performance category described in paragraph (2)(A)(i) through the use of certified EHR technology and qualified clinical data registries; and

''(II) with respect to a performance period, with respect to a year, for which a MIPS eligible professional reports such measures through the use of such EHR technology, treat such professional as satisfying the clinical quality measures reporting requirement described in subsection (o)(2)(A)(iii) for such year.

''(C) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE SCORE.—

''(i) RULE FOR CERTIFICATION.—A MIPS eligible professional who is in a practice that is certified as a patient-centered medical home or comparable specialty practice, as determined by the Secretary, with respect to a performance period shall be given the highest potential score for the performance category described in paragraph (2)(A)(iii) for such period.

''(ii) APM PARTICIPATION.—Participation by a MIPS eligible professional in an alternative payment model (as defined in section 1833(z)(3)(C)) with respect to a performance period shall earn such eligible professional a minimum score of one-half of the highest potential score for the performance category described in paragraph (2)(A)(iii) for such performance period.

''(iii) SUBCATEGORIES.—A MIPS eligible professional shall not be required to perform activities in each subcategory under paragraph (2)(B)(iii) or participate in an alternative payment model in order to achieve the highest potential score for the performance category described in paragraph (2)(A)(iii).

''(D) ACHIEVEMENT AND IMPROVEMENT.—

''(i) TAKING INTO ACCOUNT IMPROVEMENT.—Beginning with the second year to which the MIPS applies, in addition to the achievement of a MIPS eligible professional, if data sufficient to measure improvement is available, the methodology developed under subparagraph (A)—

''(I) in the case of the performance score for the performance category described in clauses (i) and (ii) of paragraph (2)(A), shall take into account the improvement of the professional; and

''(II) in the case of performance scores for other performance categories, may take into account the improvement of the professional.

''(ii) ASSIGNING HIGHER WEIGHT FOR ACHIEVEMENT.—Subject to clause (i), under the methodology developed under subparagraph (A), the Secretary may assign a higher scoring weight under subparagraph (F) with respect to the achievement of a MIPS eligible professional than with respect to any improvement of such professional applied under clause (i) with respect to a measure, activity, or category described in paragraph (2).

''(E) WEIGHTS FOR THE PERFORMANCE CATEGORIES.—

''(i) IN GENERAL.—Under the methodology developed under subparagraph (A), subject to subparagraph (F)(i) and clause (ii), the composite performance score shall be determined as follows:

''(I) QUALITY.—

''(aa) IN GENERAL.—Subject to item (bb), thirty percent of such score shall be based on performance with respect to the category described in clause (i) of paragraph (2)(A). In applying the previous sentence, the Secretary shall, as feasible, encourage the application of outcome measures within such category.

''(bb) FIRST 2 YEARS.—For the first and second years for which the MIPS applies to payments, the percentage applicable under item (aa) shall be increased in a manner such that the total percentage points of the increase under this item for the respective year equals the total number of percentage points by which the percentage applied under subclause (II)(bb) for the respective year is less than 30 percent.

''(II) RESOURCE USE.—

''(aa) IN GENERAL.—Subject to item (bb), thirty percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A).

''(bb) FIRST 2 YEARS.—For the first year for which the MIPS applies to payments, not more than 10 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A). For the second year for which the MIPS applies to payments, not more than 15 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A).

''(III) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—Fifteen percent of such score shall be based on performance with respect to the category described in clause (iii) of paragraph (2)(A).

''(IV) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—Twenty-five percent of such score shall be based on performance with respect to the category described in clause (iv) of paragraph (2)(A).

''(ii) AUTHORITY TO ADJUST PERCENTAGES IN CASE OF HIGH EHR MEANINGFUL USE ADOPTION.—In any year in which the Secretary estimates that the proportion of eligible professionals (as defined in subsection (o)(5)) who are meaningful EHR users (as determined under subsection (o)(2)) is 75 percent or greater, the Secretary may reduce the percent applicable under clause (i)(IV), but not below 15 percent. If the Secretary makes such reduction for a year, subject to subclauses (I)(bb) and (II)(bb) of clause (i), the percentages applicable under one or more of subclauses (I), (II), and (III) of clause (i) for such year shall be increased in a manner such that the total percentage points of the increase under this clause for such year equals the total number of percentage points reduced under the preceding sentence for such year.

''(F) CERTAIN FLEXIBILITY FOR WEIGHTING PERFORMANCE CATEGORIES, MEASURES, AND ACTIVITIES.—Under the methodology under subparagraph (A), if there are not sufficient measures and activities (described in paragraph (2)(B)) applicable and available to each type of eligible professional involved, the Secretary shall assign different scoring weights (including a weight of 0)—

''(i) which may vary from the scoring weights specified in subparagraph (E), for each performance category based on the extent to which the category is applicable to the type of eligible professional involved; and

''(ii) for each measure and activity specified under paragraph (2)(B) with respect to each such category based on the extent to which the measure or activity is applicable and available to the type of eligible professional involved.

''(G) RESOURCE USE.—Analysis of the performance category described in paragraph (2)(A)(ii) shall include results from the methodology described in subsection (r)(5), as appropriate.

''(H) INCLUSION OF QUALITY MEASURE DATA FROM OTHER PAYERS.—In applying subsections (k), (m), and (p) with respect to measures described in paragraph (2)(B)(i), analysis of the performance category described in paragraph (2)(A)(i) may include data submitted by MIPS eligible professionals with respect to items and services furnished to individuals who are not individuals entitled to benefits under part A or enrolled under part B.

''(I) USE OF VOLUNTARY VIRTUAL GROUPS FOR CERTAIN ASSESSMENT PURPOSES.—

''(i) IN GENERAL.—In the case of MIPS eligible professionals electing to be a virtual group under clause (ii) with respect to a performance period for a year, for purposes of applying the methodology under subparagraph (A) with respect to the performance categories described in clauses (i) and (ii) of paragraph (2)(A)—

''(I) the assessment of performance provided under such methodology with respect to such performance categories that is to be applied to each such professional in such group for such performance period shall be with respect to the combined performance of all such professionals in such group for such period; and

''(II) with respect to the composite performance score provided under this paragraph for such performance period for each such MIPS eligible professional in such virtual group, the components of the composite performance score that assess performance with respect to such performance categories shall be based on the assessment of the combined performance under subclause (I) for such performance categories and performance period.

''(ii) ELECTION OF PRACTICES TO BE A VIRTUAL GROUP.—The Secretary shall, in accordance with the requirements under clause (iii), establish and have in place a process to allow an individual MIPS eligible professional or a group practice consisting of not more than 10 MIPS eligible professionals to elect, with respect to a performance period for a year to be a virtual group under this subparagraph with at least one other such individual MIPS eligible professional or group practice. Such a virtual group may be based on appropriate classifications of providers, such as by geographic areas or by provider specialties defined by nationally recognized specialty boards of certification or equivalent certification boards.

''(iii) REQUIREMENTS.—The requirements for the process under clause (ii) shall—

''(I) provide that an election under such clause, with respect to a performance period, shall be made before the beginning of such performance period and may not be changed during such performance period;

''(II) provide that an individual MIPS eligible professional and a group practice described in clause (ii) may elect to be in no more than one virtual group for a performance period and that, in the case of such a group practice that elects to be in such virtual group for such performance period, such election applies to all MIPS eligible professionals in such group practice;

''(III) provide that a virtual group be a combination of tax identification numbers;

''(IV) provide for formal written agreements among MIPS eligible professionals electing to be a virtual group under this subparagraph; and

''(V) include such other requirements as the Secretary determines appropriate.

''(6) MIPS PAYMENTS.—

''(A) MIPS ADJUSTMENT FACTOR.—Taking into account paragraph (1)(G), the Secretary shall specify a MIPS adjustment factor for each MIPS eligible professional for a year. Such MIPS adjustment factor for a MIPS eligible professional for a year shall be in the form of a percent and shall be determined—

''(i) by comparing the composite performance score of the eligible professional for such year to the performance threshold established under subparagraph (D)(i) for such year;

''(ii) in a manner such that the adjustment factors specified under this subparagraph for a year result in differential payments under this paragraph reflecting that—

''(I) MIPS eligible professionals with composite performance scores for such year at or above such performance threshold for such year receive zero or positive payment adjustment factors for such year in accordance

with clause (iii), with such professionals having higher composite performance scores receiving higher adjustment factors; and

''(II) MIPS eligible professionals with composite performance scores for such year below such performance threshold for such year receive negative payment adjustment factors for such year in accordance with clause (iv), with such professionals having lower composite performance scores receiving lower adjustment factors;

''(iii) in a manner such that MIPS eligible professionals with composite scores described in clause (ii)(I) for such year, subject to clauses (i) and (ii) of subparagraph (F), receive a zero or positive adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the applicable percent specified in subparagraph (B) is assigned for a score of 100; and

''(iv) in a manner such that—

''(I) subject to subclause (II), MIPS eligible professionals with composite performance scores described in clause (ii)(II) for such year receive a negative payment adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the negative of the applicable percent specified in subparagraph (B) is assigned for a score of 0; and

''(II) MIPS eligible professionals with composite performance scores that are equal to or greater than 0, but not greater than ¼ of the performance threshold specified under subparagraph (D)(i) for such year, receive a negative payment adjustment factor that is equal to the negative of the applicable percent specified in subparagraph (B) for such year.

''(B) APPLICABLE PERCENT DEFINED.—For purposes of this paragraph, the term 'applicable percent' means—

''(i) for 2019, 4 percent;

''(ii) for 2020, 5 percent;

''(iii) for 2021, 7 percent; and

''(iv) for 2022 and subsequent years, 9 percent.

''(C) ADDITIONAL MIPS ADJUSTMENT FACTORS FOR EXCEPTIONAL PERFORMANCE.—For 2019 and each subsequent year through 2024, in the case of a MIPS eligible professional with a composite performance score for a year at or above the additional performance threshold under subparagraph (D)(ii) for such year, in addition to the MIPS adjustment factor under subparagraph (A) for the eligible professional for such year, subject to subparagraph (F)(iv), the Secretary shall specify an additional positive MIPS adjustment factor for such professional and year. Such additional MIPS adjustment factors shall be in the form of a percent and determined by the Secretary in a manner such that professionals having higher composite performance scores above the additional performance threshold receive higher additional MIPS adjustment factors.

''(D) ESTABLISHMENT OF PERFORMANCE THRESHOLDS.—

''(i) PERFORMANCE THRESHOLD.—For each year of the MIPS, the Secretary shall compute a performance threshold with respect to which the composite performance score of MIPS eligible professionals shall be compared for purposes of determining adjustment factors under subparagraph (A) that are positive, negative, and zero. Such performance threshold for a year shall be the mean or median (as selected by the Secretary) of the composite performance scores for all MIPS eligible professionals with respect to a prior period specified by the Secretary. The Secretary may reassess the selection of the mean or median under the previous sentence every 3 years.

''(ii) ADDITIONAL PERFORMANCE THRESHOLD FOR EXCEPTIONAL PERFORMANCE.—In addition to the performance threshold under clause (i), for each year of the MIPS, the Secretary shall compute an additional performance threshold for purposes of determining the additional MIPS adjustment factors under subparagraph (C). For each such year, the Secretary shall apply either of the following methods for computing such additional performance threshold for such a year:

''(I) The threshold shall be the score that is equal to the 25th percentile of the range of possible composite performance scores above the performance threshold determined under clause (i).

''(II) The threshold shall be the score that is equal to the 25th percentile of the actual composite performance scores for MIPS eligible professionals with composite performance scores at or above the performance threshold with respect to the prior period described in clause (i).

''(iii) SPECIAL RULE FOR INITIAL 2 YEARS.—With respect to each of the first two years to which the MIPS applies, the Secretary shall, prior to the performance period for such years, establish a performance threshold for purposes of determining MIPS adjustment factors under subparagraph (A) and a threshold for purposes of determining additional MIPS adjustment factors under subparagraph (C). Each such performance threshold shall—

''(I) be based on a period prior to such performance periods; and

''(II) take into account—

''(aa) data available with respect to performance on measures and activities that may be used under the performance categories under subparagraph (2)(B); and

''(bb) other factors determined appropriate by the Secretary.

''(E) APPLICATION OF MIPS ADJUSTMENT FACTORS.—In the case of items and services furnished by a MIPS eligible professional during a year (beginning with 2019), the amount otherwise paid under this part with respect to such items and services and MIPS eligible professional for such year, shall be multiplied by—

''(i) 1, plus

''(ii) the sum of—

''(I) the MIPS adjustment factor determined under subparagraph (A) divided by 100, and

''(II) as applicable, the additional MIPS adjustment factor determined under subparagraph (C) divided by 100.

''(F) AGGREGATE APPLICATION OF MIPS ADJUSTMENT FACTORS.—

''(i) APPLICATION OF SCALING FACTOR.—

''(I) IN GENERAL.—With respect to positive MIPS adjustment factors under subparagraph (A)(ii)(I) for eligible professionals whose composite performance score is above the performance threshold under subparagraph (D)(i) for such year, subject to subclause (II), the Secretary shall increase or decrease such adjustment factors by a scaling factor in order to ensure that the budget neutrality requirement of clause (ii) is met.

''(II) SCALING FACTOR LIMIT.—In no case may the scaling factor applied under this clause exceed 3.0.

''(ii) BUDGET NEUTRALITY REQUIREMENT.—

''(I) IN GENERAL.—Subject to clause (iii), the Secretary shall ensure that the estimated amount described in subclause (II) for a year is equal to the estimated amount described in subclause (III) for such year.

''(II) AGGREGATE INCREASES.—The amount described in this subclause is the estimated increase in the aggregate allowed charges resulting from the application of positive MIPS adjustment factors under subparagraph (A) (after application of the scaling factor described in clause (i)) to MIPS eligible professionals whose composite performance score for a year is above the performance threshold under subparagraph (D)(i) for such year.

''(III) AGGREGATE DECREASES.—The amount described in this subclause is the estimated decrease in the aggregate allowed charges resulting from the application of negative MIPS adjustment factors under subparagraph (A) to MIPS eligible professionals whose composite performance score for a year is below the performance threshold under subparagraph (D)(i) for such year.

''(iii) EXCEPTIONS.—

''(I) In the case that all MIPS eligible professionals receive composite performance scores for a year that are below the performance threshold under subparagraph (D)(i) for such year, the negative MIPS adjustment factors under subparagraph (A) shall apply with respect to such MIPS eligible professionals and the budget neutrality requirement of clause (ii) and the additional adjustment factors under clause (iv) shall not apply for such year.

''(II) In the case that, with respect to a year, the application of clause (i) results in a scaling factor equal to the maximum scaling factor specified in clause (i)(II), such scaling factor shall apply and the budget neutrality requirement of clause (ii) shall not apply for such year.

''(iv) ADDITIONAL INCENTIVE PAYMENT ADJUSTMENTS.—

''(I) IN GENERAL.—Subject to subclause (II), in specifying the MIPS additional adjustment factors under subparagraph (C) for each applicable MIPS eligible professional for a year, the Secretary shall ensure that the estimated aggregate increase in payments under this part resulting from the application of such additional adjustment factors for MIPS eligible professionals in a year shall be equal (as estimated by the Secretary) to $500,000,000 for each year beginning with 2019 and ending with 2024.

''(II) LIMITATION ON ADDITIONAL INCENTIVE PAYMENT ADJUSTMENTS.—The MIPS additional adjustment factor under subparagraph (C) for a year for an applicable MIPS eligible professional whose composite performance score is above the additional performance threshold under subparagraph (D)(ii) for such year shall not exceed 10 percent. The application of the previous sentence may result in an aggregate amount of additional incentive payments that are less than the amount specified in subclause (I).

''(7) ANNOUNCEMENT OF RESULT OF ADJUSTMENTS.—Under the MIPS, the Secretary shall, not later than 30 days prior to January 1 of the year involved, make available to MIPS eligible professionals the MIPS adjustment factor (and, as applicable, the additional MIPS adjustment factor) under paragraph (6) applicable to the eligible professional for items and services furnished by the professional for such year. The Secretary may include such information in the confidential feedback under paragraph (12).

''(8) NO EFFECT IN SUBSEQUENT YEARS.—The MIPS adjustment factors and additional MIPS adjustment factors under paragraph (6) shall apply only with respect to the year involved, and the Secretary shall not take into account such adjustment factors in making payments to a MIPS eligible professional under this part in a subsequent year.

''(9) PUBLIC REPORTING.—

''(A) IN GENERAL.—The Secretary shall, in an easily understandable format, make available on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services the following:

''(i) Information regarding the performance of MIPS eligible professionals under the MIPS, which—

''(I) shall include the composite score for each such MIPS eligible professional and the performance of each such MIPS eligible professional with respect to each performance category; and

''(II) may include the performance of each such MIPS eligible professional with respect to each measure or activity specified in paragraph (2)(B).

''(ii) The names of eligible professionals in eligible alternative payment models (as defined in section 1833(z)(3)(D)) and, to the extent feasible, the names of such eligible alternative payment models and performance of such models.

''(B) DISCLOSURE.—The information made available under this paragraph shall indicate, where appropriate, that publicized information may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated.

''(C) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall provide for an opportunity for a professional described in subparagraph (A) to review, and submit corrections for, the information to be made public with respect to the professional under such subparagraph prior to such information being made public.

''(D) AGGREGATE INFORMATION.—The Secretary shall periodically post on the Physician Compare Internet website aggregate information on the MIPS, including the range of composite scores for all MIPS eligible professionals and the range of the performance of all MIPS eligible professionals with respect to each performance category.

''(10) CONSULTATION.—The Secretary shall consult with stakeholders in carrying out the MIPS, including for the identification of measures and activities under paragraph (2)(B) and the methodologies developed under paragraphs (5)(A) and (6) and regarding the use of qualified clinical data registries. Such consultation shall include the use of a request for information or other mechanisms determined appropriate.

''(11) TECHNICAL ASSISTANCE TO SMALL PRACTICES AND PRACTICES IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

''(A) IN GENERAL.—The Secretary shall enter into contracts or agreements with appropriate entities (such as quality improvement organizations, regional extension centers (as described in section 3012(c) of the Public Health Service Act), or regional health collaboratives) to offer guidance and assistance to MIPS eligible professionals in practices of 15 or fewer professionals (with priority given to such practices located in rural areas, health professional shortage areas (as designated under in section 332(a)(1)(A) of such Act), and medically underserved areas, and practices with low composite scores) with respect to—

''(i) the performance categories described in clauses (i) through (iv) of paragraph (2)(A); or

''(ii) how to transition to the implementation of and participation in an alternative payment model as described in section 1833(z)(3)(C).

''(B) FUNDING FOR TECHNICAL ASSISTANCE.—For purposes of implementing subparagraph (A), the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 to the Centers for Medicare & Medicaid Services Program Management Account of $20,000,000 for each of fiscal years 2016 through 2020. Amounts transferred under this subparagraph for a fiscal year shall be available until expended.

''(12) FEEDBACK AND INFORMATION TO IMPROVE PERFORMANCE.—

''(A) PERFORMANCE FEEDBACK.—

''(i) IN GENERAL.—Beginning July 1, 2017, the Secretary—

''(I) shall make available timely (such as quarterly) confidential feedback to MIPS eligible professionals on the performance of such professionals with respect to the performance categories under clauses (i) and (ii) of paragraph (2)(A); and

''(II) may make available confidential feedback to such professionals on the performance of such professionals with respect to the performance categories under clauses (iii) and (iv) of such paragraph.

''(ii) MECHANISMS.—The Secretary may use one or more mechanisms to make feedback available under clause (i), which may include use of a web-based portal or other mechanisms determined appropriate by the Secretary. With respect to the performance category described in paragraph (2)(A)(i), feedback under this subparagraph shall, to the extent an eligible professional chooses to participate in a data registry for purposes of this subsection (including registries under subsections (k) and (m)), be provided based on performance on quality measures reported through the use of such registries. With respect to any other performance category described in paragraph (2)(A), the Secretary shall encourage provision of feedback through qualified clinical data registries as described in subsection (m)(3)(E)).

''(iii) USE OF DATA.—For purposes of clause (i), the Secretary may use data, with respect to a MIPS eligible professional, from periods prior to the current performance period and may use rolling periods in order to make illustrative calculations about the performance of such professional.

''(iv) DISCLOSURE EXEMPTION.—Feedback made available under this subparagraph shall be exempt from disclosure under section 552 of title 5, United States Code.

''(v) RECEIPT OF INFORMATION.—The Secretary may use the mechanisms established under clause (ii) to receive information from professionals, such as information with respect to this subsection.

''(B) ADDITIONAL INFORMATION.—

''(i) IN GENERAL.—Beginning July 1, 2018, the Secretary shall make available to MIPS eligible professionals information, with respect to individuals who are patients of such MIPS eligible professionals, about items and services for which payment is made under this title that are furnished to such individuals by other suppliers and providers of services, which may include information described in clause (ii). Such information may be made available under the previous sentence to such MIPS eligible professionals by mechanisms determined appropriate by the Secretary, which may include use of a web-based portal. Such information may be made available in accordance with the same or similar terms as data are made available to accountable care organizations participating in the shared savings program under section 1899.

''(ii) TYPE OF INFORMATION.—For purposes of clause (i), the information described in this clause, is the following:

''(I) With respect to selected items and services (as determined appropriate by the Secretary) for which payment is made under this title and that are furnished to individuals, who are patients of a MIPS eligible professional, by another supplier or provider of services during the most recent period for which data are available (such as the most recent three-month period), such as the name of such providers furnishing such items and services to such patients during such period, the types of such items and services so furnished, and the dates such items and services were so furnished.

''(II) Historical data, such as averages and other measures of the distribution if appropriate, of the total, and components of, allowed charges (and other figures as determined appropriate by the Secretary).

''(13) REVIEW.—

''(A) TARGETED REVIEW.—The Secretary shall establish a process under which a MIPS eligible professional may seek an informal review of the calculation of the MIPS adjustment factor (or factors) applicable to such eligible professional under this subsection for a year. The results of a review conducted pursuant to the previous sentence shall not be taken into account for purposes of paragraph (6) with respect to a year (other than with respect to the calculation of such eligible professional's MIPS adjustment factor for such year or additional MIPS adjustment factor for such year) after the factors determined in subparagraph (A) and subparagraph (C) of such paragraph have been determined for such year.

''(B) LIMITATION.—Except as provided for in subparagraph (A), there shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

''(i) The methodology used to determine the amount of the MIPS adjustment factor under paragraph (6)(A) and the amount of the additional MIPS adjustment factor under paragraph (6)(C) and the determination of such amounts.

''(ii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

''(iii) The identification of measures and activities specified under paragraph (2)(B) and information made public or posted on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services under paragraph (9).

''(iv) The methodology developed under paragraph (5) that is used to calculate performance scores and the calculation of such scores, including the weighting of measures and activities under such methodology.''.

(2) GAO REPORTS.—

(A) EVALUATION OF ELIGIBLE PROFESSIONAL MIPS.—Not later than October 1, 2021, the Comptroller General of the United States shall submit to Congress a report evaluating the eligible professional Merit-based Incentive Payment System under subsection (q) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as added by paragraph (1). Such report shall—

(i) examine the distribution of the composite performance scores and MIPS adjustment factors (and additional MIPS adjustment factors) for MIPS eligible professionals (as defined in subsection (q)(1)(c) of such section) under such program, and patterns relating to such scores and adjustment factors, including based on type of provider, practice size, geographic location, and patient mix;

(ii) provide recommendations for improving such program;

(iii) evaluate the impact of technical assistance funding under section 1848(q)(11) of the Social Security Act, as added by paragraph (1), on the ability of professionals to improve within such program or successfully transition to an alternative payment model (as defined in section 1833(z)(3) of the Social Security Act, as added by subsection (e)), with priority for such evaluation given to practices located in rural areas, health professional shortage areas (as designated in section 332(a)(1)(A) of the Public Health Service Act), and medically underserved areas; and

(iv) provide recommendations for optimizing the use of such technical assistance funds.

(B) STUDY TO EXAMINE ALIGNMENT OF QUALITY MEASURES USED IN PUBLIC AND PRIVATE PROGRAMS.—

(i) IN GENERAL.—Not later than 18 months after the date of the enactment of this Act,

the Comptroller General of the United States shall submit to Congress a report that—

(I) compares the similarities and differences in the use of quality measures under the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act, the Medicare Advantage program under part C of such title, selected State Medicaid programs under title XIX of such Act, and private payer arrangements; and

(II) makes recommendations on how to reduce the administrative burden involved in applying such quality measures.

(ii) REQUIREMENTS.—The report under clause (i) shall—

(I) consider those measures applicable to individuals entitled to, or enrolled for, benefits under such part A, or enrolled under such part B and individuals under the age of 65; and

(II) focus on those measures that comprise the most significant component of the quality performance category of the eligible professional MIPS incentive program under subsection (q) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as added by paragraph (1).

(C) STUDY ON ROLE OF INDEPENDENT RISK MANAGERS.—Not later than January 1, 2017, the Comptroller General of the United States shall submit to Congress a report examining whether entities that pool financial risk for physician practices, such as independent risk managers, can play a role in supporting physician practices, particularly small physician practices, in assuming financial risk for the treatment of patients. Such report shall examine barriers that small physician practices currently face in assuming financial risk for treating patients, the types of risk management entities that could assist physician practices in participating in two-sided risk payment models, and how such entities could assist with risk management and with quality improvement activities. Such report shall also include an analysis of any existing legal barriers to such arrangements.

(D) STUDY TO EXAMINE RURAL AND HEALTH PROFESSIONAL SHORTAGE AREA ALTERNATIVE PAYMENT MODELS.—Not later than October 1, 2021, the Comptroller General of the United States shall submit to Congress a report that examines the transition of professionals in rural areas, health professional shortage areas (as designated in section 332(a)(1)(A) of the Public Health Service Act), or medically underserved areas to an alternative payment model (as defined in section 1833(z)(3) of the Social Security Act, as added by subsection (e)). Such report shall make recommendations for removing administrative barriers to practices, including small practices consisting of 15 or fewer professionals, in rural areas, health professional shortage areas, and medically underserved areas to participation in such models.

(3) FUNDING FOR IMPLEMENTATION.—For purposes of implementing the provisions of and the amendments made by this section, the Secretary of Health and Human Services shall provide for the transfer of $80,000,000 from the Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) to the Centers for Medicare & Medicaid Program Management Account for each of the fiscal years 2015 through 2019. Amounts transferred under this paragraph shall be available until expended.

(d) IMPROVING QUALITY REPORTING FOR COMPOSITE SCORES.—

(1) CHANGES FOR GROUP REPORTING OPTION.—

(A) IN GENERAL.—Section 1848(m)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(C)(ii)) is amended by inserting ''and, for 2016 and subsequent years, may provide'' after ''shall provide''.

(B) CLARIFICATION OF QUALIFIED CLINICAL DATA REGISTRY REPORTING TO GROUP PRACTICES.—Section 1848(m)(3)(D) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(D)) is amended by inserting ''and, for 2016 and subsequent years, subparagraph (A) or (C)'' after ''subparagraph (A)''.

(2) CHANGES FOR MULTIPLE REPORTING PERIODS AND ALTERNATIVE CRITERIA FOR SATISFACTORY REPORTING.—Section 1848(m)(5)(F) of the Social Security Act (42 U.S.C. 1395w–4(m)(5)(F)) is amended—

(A) by striking ''and subsequent years'' and inserting ''through reporting periods occurring in 2015''; and

(B) by inserting ''and, for reporting periods occurring in 2016 and subsequent years, the Secretary may establish'' after ''shall establish''.

(3) PHYSICIAN FEEDBACK PROGRAM REPORTS SUCCEEDED BY REPORTS UNDER MIPS.—Section 1848(n) of the Social Security Act (42 U.S.C. 1395w–4(n)) is amended by adding at the end the following new paragraph:

''(11) REPORTS ENDING WITH 2017.—Reports under the Program shall not be provided after December 31, 2017. See subsection (q)(12) for reports under the eligible professionals Merit-based Incentive Payment System.''.

(4) COORDINATION WITH SATISFYING MEANINGFUL EHR USE CLINICAL QUALITY MEASURE REPORTING REQUIREMENT.—Section 1848(o)(2)(A)(iii) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)(A)(iii)) is amended by inserting ''and subsection (q)(5)(B)(ii)(II)'' after ''Subject to subparagraph (B)(ii)''.

(e) PROMOTING ALTERNATIVE PAYMENT MODELS.—

(1) INCREASING TRANSPARENCY OF PHYSICIAN-FOCUSED PAYMENT MODELS.—Section 1868 of the Social Security Act (42 U.S.C. 1395ee) is amended by adding at the end the following new subsection:

''(c) PHYSICIAN-FOCUSED PAYMENT MODELS.—

''(1) TECHNICAL ADVISORY COMMITTEE.—

''(A) ESTABLISHMENT.—There is established an ad hoc committee to be known as the 'Physician-Focused Payment Model Technical Advisory Committee' (referred to in this subsection as the 'Committee').

''(B) MEMBERSHIP.—

''(i) NUMBER AND APPOINTMENT.—The Committee shall be composed of 11 members appointed by the Comptroller General of the United States.

''(ii) QUALIFICATIONS.—The membership of the Committee shall include individuals with national recognition for their expertise in physician-focused payment models and related delivery of care. No more than 5 members of the Committee shall be providers of services or suppliers, or representatives of providers of services or suppliers.

''(iii) PROHIBITION ON FEDERAL EMPLOYMENT.—A member of the Committee shall not be an employee of the Federal Government.

''(iv) ETHICS DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Committee of financial and other potential conflicts of interest relating to such members. Members of the Committee shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

''(v) DATE OF INITIAL APPOINTMENTS.—The initial appointments of members of the Committee shall be made by not later than 180 days after the date of enactment of this subsection.

''(C) TERM; VACANCIES.—

''(i) TERM.—The terms of members of the Committee shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

''(ii) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Committee shall be filled in the manner in which the original appointment was made.

''(D) DUTIES.—The Committee shall meet, as needed, to provide comments and recommendations to the Secretary, as described in paragraph (2)(C), on physician-focused payment models.

''(E) COMPENSATION OF MEMBERS.—

''(i) IN GENERAL.—Except as provided in clause (ii), a member of the Committee shall serve without compensation.

''(ii) TRAVEL EXPENSES.—A member of the Committee shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for an employee of an agency under subchapter I of chapter 57 of title 5, United States Code, while away from the home or regular place of business of the member in the performance of the duties of the Committee.

''(F) OPERATIONAL AND TECHNICAL SUPPORT.—

''(i) IN GENERAL.—The Assistant Secretary for Planning and Evaluation shall provide technical and operational support for the Committee, which may be by use of a contractor. The Office of the Actuary of the Centers for Medicare & Medicaid Services shall provide to the Committee actuarial assistance as needed.

''(ii) FUNDING.—The Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, such amounts as are necessary to carry out this paragraph (not to exceed $5,000,000) for fiscal year 2015 and each subsequent fiscal year. Any amounts transferred under the preceding sentence for a fiscal year shall remain available until expended.

''(G) APPLICATION.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Committee.

''(2) CRITERIA AND PROCESS FOR SUBMISSION AND REVIEW OF PHYSICIAN-FOCUSED PAYMENT MODELS.—

''(A) CRITERIA FOR ASSESSING PHYSICIAN-FOCUSED PAYMENT MODELS.—

''(i) RULEMAKING.—Not later than November 1, 2016, the Secretary shall, through notice and comment rulemaking, following a request for information, establish criteria for physician-focused payment models, including models for specialist physicians, that could be used by the Committee for making comments and recommendations pursuant to paragraph (1)(D).

''(ii) MEDPAC SUBMISSION OF COMMENTS.—During the comment period for the proposed rule described in clause (i), the Medicare Payment Advisory Commission may submit comments to the Secretary on the proposed criteria under such clause.

''(iii) UPDATING.—The Secretary may update the criteria established under this subparagraph through rulemaking.

''(B) STAKEHOLDER SUBMISSION OF PHYSICIAN-FOCUSED PAYMENT MODELS.—On an ongoing basis, individuals and stakeholder entities may submit to the Committee proposals for physician-focused payment models that such individuals and entities believe meet the criteria described in subparagraph (A).

''(C) COMMITTEE REVIEW OF MODELS SUBMITTED.—The Committee shall, on a periodic

basis, review models submitted under subparagraph (B), prepare comments and recommendations regarding whether such models meet the criteria described in subparagraph (A), and submit such comments and recommendations to the Secretary.

''(D) SECRETARY REVIEW AND RESPONSE.—The Secretary shall review the comments and recommendations submitted by the Committee under subparagraph (C) and post a detailed response to such comments and recommendations on the Internet website of the Centers for Medicare & Medicaid Services.

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to impact the development or testing of models under this title or titles XI, XIX, or XXI.''.

(2) INCENTIVE PAYMENTS FOR PARTICIPATION IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—Section 1833 of the Social Security Act (42 U.S.C. 13951) is amended by adding at the end the following new subsection:

''(z) INCENTIVE PAYMENTS FOR PARTICIPATION IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—

''(1) PAYMENT INCENTIVE.—

''(A) IN GENERAL.—In the case of covered professional services furnished by an eligible professional during a year that is in the period beginning with 2019 and ending with 2024 and for which the professional is a qualifying APM participant with respect to such year, in addition to the amount of payment that would otherwise be made for such covered professional services under this part for such year, there also shall be paid to such professional an amount equal to 5 percent of the estimated aggregate payment amounts for such covered professional services under this part for the preceding year. For purposes of the previous sentence, the payment amount for the preceding year may be an estimation for the full preceding year based on a period of such preceding year that is less than the full year. The Secretary shall establish policies to implement this subparagraph in cases in which payment for covered professional services furnished by a qualifying APM participant in an alternative payment model—

''(i) is made to an eligible alternative payment entity rather than directly to the qualifying APM participant; or

''(ii) is made on a basis other than a fee-for-service basis (such as payment on a capitated basis).

''(B) FORM OF PAYMENT.—Payments under this subsection shall be made in a lump sum, on an annual basis, as soon as practicable.

''(C) TREATMENT OF PAYMENT INCENTIVE.—Payments under this subsection shall not be taken into account for purposes of determining actual expenditures under an alternative payment model and for purposes of determining or rebasing any benchmarks used under the alternative payment model.

''(D) COORDINATION.—The amount of the additional payment under this subsection or subsection (m) shall be determined without regard to any additional payment under subsection (m) and this subsection, respectively. The amount of the additional payment under this subsection or subsection (x) shall be determined without regard to any additional payment under subsection (x) and this subsection, respectively. The amount of the additional payment under this subsection or subsection (y) shall be determined without regard to any additional payment under subsection (y) and this subsection, respectively.

''(2) QUALIFYING APM PARTICIPANT.—For purposes of this subsection, the term 'qualifying APM participant' means the following:

''(A) 2019 AND 2020.—With respect to 2019 and 2020, an eligible professional for whom the Secretary determines that at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

''(B) 2021 AND 2022.—With respect to 2021 and 2022, an eligible professional described in either of the following clauses:

''(i) MEDICARE PAYMENT THRESHOLD OPTION.—An eligible professional for whom the Secretary determines that at least 50 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

''(ii) COMBINATION ALL-PAYER AND MEDICARE PAYMENT THRESHOLD OPTION.—An eligible professional—

''(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 50 percent of the sum of—

''(aa) payments described in clause (i); and

''(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs and other than payments made under title XIX in a State in which no medical home or alternative payment model is available under the State program under that title),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

''(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity; and

''(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

''(iii) REQUIREMENT.—For purposes of clause (ii)(I)—

''(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made to an eligible alternative payment entity; and

''(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under arrangements in which—

''(aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;

''(bb) certified EHR technology is used; and

''(cc) the eligible professional participates in an entity that—

''(AA) bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures; or

''(BB) with respect to beneficiaries under title XIX, is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c).

''(C) BEGINNING IN 2023.—With respect to 2023 and each subsequent year, an eligible professional described in either of the following clauses:

''(i) MEDICARE PAYMENT THRESHOLD OPTION.—An eligible professional for whom the Secretary determines that at least 75 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

''(ii) COMBINATION ALL-PAYER AND MEDICARE PAYMENT THRESHOLD OPTION.—An eligible professional—

''(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 75 percent of the sum of—

''(aa) payments described in clause (i); and

''(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs and other than payments made under title XIX in a State in which no medical home or alternative payment model is available under the State program under that title),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

''(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity; and

''(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

''(iii) REQUIREMENT.—For purposes of clause (ii)(I)—

''(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made to an eligible alternative payment entity; and

''(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under arrangements in which—

''(aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;

''(bb) certified EHR technology is used; and

''(cc) the eligible professional participates in an entity that—

''(AA) bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures; or

''(BB) with respect to beneficiaries under title XIX, is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c).

''(D) USE OF PATIENT APPROACH.—The Secretary may base the determination of whether an eligible professional is a qualifying APM participant under this subsection and the determination of whether an eligible professional is a partial qualifying APM participant under section 1848(q)(1)(C)(iii) by using counts of patients in lieu of using payments and using the same or similar percentage criteria (as specified in this subsection and such section, respectively), as the Secretary determines appropriate.

''(3) ADDITIONAL DEFINITIONS.—In this subsection:

''(A) COVERED PROFESSIONAL SERVICES.—The term 'covered professional services' has the meaning given that term in section 1848(k)(3)(A).

''(B) ELIGIBLE PROFESSIONAL.—The term 'eligible professional' has the meaning given

that term in section 1848(k)(3)(B) and includes a group that includes such professionals.

''(C) ALTERNATIVE PAYMENT MODEL (APM).—The term 'alternative payment model' means, other than for purposes of subparagraphs (B)(ii)(I)(bb) and (C)(ii)(I)(bb) of paragraph (2), any of the following:

''(i) A model under section 1115A (other than a health care innovation award).

''(ii) The shared savings program under section 1899.

''(iii) A demonstration under section 1866C.

''(iv) A demonstration required by Federal law.

''(D) ELIGIBLE ALTERNATIVE PAYMENT ENTITY.—The term 'eligible alternative payment entity' means, with respect to a year, an entity that—

''(i) participates in an alternative payment model that—

''(I) requires participants in such model to use certified EHR technology (as defined in subsection (o)(4)); and

''(II) provides for payment for covered professional services based on quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i); and

''(ii)(I) bears financial risk for monetary losses under such alternative payment model that are in excess of a nominal amount; or

''(II) is a medical home expanded under section 1115A(c).

''(4) LIMITATION.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, of the following:

''(A) The determination that an eligible professional is a qualifying APM participant under paragraph (2) and the determination that an entity is an eligible alternative payment entity under paragraph (3)(D).

''(B) The determination of the amount of the 5 percent payment incentive under paragraph (1)(A), including any estimation as part of such determination.''.

(3) COORDINATION CONFORMING AMENDMENTS.—Section 1833 of the Social Security Act (42 U.S.C. 13951) is further amended—

(A) in subsection (x)(3), by adding at the end the following new sentence: ''The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.''; and

(B) in subsection (y)(3), by adding at the end the following new sentence: ''The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.''.

(4) ENCOURAGING DEVELOPMENT AND TESTING OF CERTAIN MODELS.—Section 1115A(b)(2) of the Social Security Act (42 U.S.C. 1315a(b)(2)) is amended—

(A) in subparagraph (B), by adding at the end the following new clauses:

''(xxi) Focusing primarily on physicians' services (as defined in section 1848(j)(3)) furnished by physicians who are not primary care practitioners.

''(xxii) Focusing on practices of 15 or fewer professionals.

''(xxiii) Focusing on risk-based models for small physician practices which may involve two-sided risk and prospective patient assignment, and which examine risk-adjusted decreases in mortality rates, hospital readmissions rates, and other relevant and appropriate clinical measures.

''(xxiv) Focusing primarily on title XIX, working in conjunction with the Center for Medicaid and CHIP Services.''; and

(B) in subparagraph (C)(viii), by striking ''other public sector or private sector payers'' and inserting ''other public sector payers, private sector payers, or statewide payment models''.

(5) CONSTRUCTION REGARDING TELEHEALTH SERVICES.—Nothing in the provisions of, or amendments made by, this title shall be construed as precluding an alternative payment model or a qualifying APM participant (as those terms are defined in section 1833(z) of the Social Security Act, as added by paragraph (1)) from furnishing a telehealth service for which payment is not made under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)).

(6) INTEGRATING MEDICARE ADVANTAGE ALTERNATIVE PAYMENT MODELS.—Not later than July 1, 2016, the Secretary of Health and Human Services shall submit to Congress a study that examines the feasibility of integrating alternative payment models in the Medicare Advantage payment system. The study shall include the feasibility of including a value-based modifier and whether such modifier should be budget neutral.

(7) STUDY AND REPORT ON FRAUD RELATED TO ALTERNATIVE PAYMENT MODELS UNDER THE MEDICARE PROGRAM.—

(A) STUDY.—The Secretary of Health and Human Services, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct a study that—

(i) examines the applicability of the Federal fraud prevention laws to items and services furnished under title XVIII of the Social Security Act for which payment is made under an alternative payment model (as defined in section 1833(z)(3)(C) of such Act (42 U.S.C. 13951(z)(3)(C)));

(ii) identifies aspects of such alternative payment models that are vulnerable to fraudulent activity; and

(iii) examines the implications of waivers to such laws granted in support of such alternative payment models, including under any potential expansion of such models.

(B) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subparagraph (A). Such report shall include recommendations for actions to be taken to reduce the vulnerability of such alternative payment models to fraudulent activity. Such report also shall include, as appropriate, recommendations of the Inspector General for changes in Federal fraud prevention laws to reduce such vulnerability.

(f) COLLABORATING WITH THE PHYSICIAN, PRACTITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO IMPROVE RESOURCE USE MEASUREMENT.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by subsection (c), is further amended by adding at the end the following new subsection:

''(r) COLLABORATING WITH THE PHYSICIAN, PRACTITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO IMPROVE RESOURCE USE MEASUREMENT.—

''(1) IN GENERAL.—In order to involve the physician, practitioner, and other stakeholder communities in enhancing the infrastructure for resource use measurement, including for purposes of the Merit-based Incentive Payment System under subsection (q) and alternative payment models under section 1833(z), the Secretary shall undertake the steps described in the succeeding provisions of this subsection.

''(2) DEVELOPMENT OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—

''(A) IN GENERAL.—In order to classify similar patients into care episode groups and patient condition groups, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

''(B) PUBLIC AVAILABILITY OF EXISTING EFFORTS TO DESIGN AN EPISODE GROUPER.—Not later than 180 days after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the episode groups developed pursuant to subsection (n)(9)(A) and related descriptive information.

''(C) STAKEHOLDER INPUT.—The Secretary shall accept, through the date that is 120 days after the day the Secretary posts the list pursuant to subparagraph (B), suggestions from physician specialty societies, applicable practitioner organizations, and other stakeholders for episode groups in addition to those posted pursuant to such subparagraph, and specific clinical criteria and patient characteristics to classify patients into—

''(i) care episode groups; and

''(ii) patient condition groups.

''(D) DEVELOPMENT OF PROPOSED CLASSIFICATION CODES.—

''(i) IN GENERAL.—Taking into account the information described in subparagraph (B) and the information received under subparagraph (C), the Secretary shall—

''(I) establish care episode groups and patient condition groups, which account for a target of an estimated ½ of expenditures under parts A and B (with such target increasing over time as appropriate); and

''(II) assign codes to such groups.

''(ii) CARE EPISODE GROUPS.—In establishing the care episode groups under clause (i), the Secretary shall take into account—

''(I) the patient's clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization occurs, and the principal procedures or services furnished; and

''(II) other factors determined appropriate by the Secretary.

''(iii) PATIENT CONDITION GROUPS.—In establishing the patient condition groups under clause (i), the Secretary shall take into account—

''(I) the patient's clinical history at the time of a medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period, such as 3 months); and

''(II) other factors determined appropriate by the Secretary, such as eligibility status under this title (including eligibility under section 226(a), 226(b), or 226A, and dual eligibility under this title and title XIX).

''(E) DRAFT CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—Not later than 270 days after the end of the comment period described in subparagraph (C), the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the care episode and patient condition codes established under subparagraph (D) (and the criteria and characteristics assigned to such code).

''(F) SOLICITATION OF INPUT.—The Secretary shall seek, through the date that is 120 days after the Secretary posts the list pursuant to subparagraph (E), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the care episode and patient condition groups (and codes) posted under subparagraph (E). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include use of open door forums, town

hall meetings, or other appropriate mechanisms.

''(G) OPERATIONAL LIST OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CODES.—Not later than 270 days after the end of the comment period described in subparagraph (F), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of care episode and patient condition codes (and the criteria and characteristics assigned to such code).

''(H) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2018), the Secretary shall, through rulemaking, make revisions to the operational lists of care episode and patient condition codes as the Secretary determines may be appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

''(3) ATTRIBUTION OF PATIENTS TO PHYSICIANS OR PRACTITIONERS.—

''(A) IN GENERAL.—In order to facilitate the attribution of patients and episodes (in whole or in part) to one or more physicians or applicable practitioners furnishing items and services, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

''(B) DEVELOPMENT OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—The Secretary shall develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. Such patient relationship categories shall include different relationships of the physician or applicable practitioner to the patient (and the codes may reflect combinations of such categories), such as a physician or applicable practitioner who—

''(i) considers themself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;

''(ii) considers themself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;

''(iii) furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;

''(iv) furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or

''(v) furnishes items and services only as ordered by another physician or practitioner.

''(C) DRAFT LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than one year after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the patient relationship categories and codes developed under subparagraph (B).

''(D) STAKEHOLDER INPUT.—The Secretary shall seek, through the date that is 120 days after the Secretary posts the list pursuant to subparagraph (C), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the patient relationship categories and codes posted under subparagraph (C). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, web-based forums, or other appropriate mechanisms.

''(E) OPERATIONAL LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than 240 days after the end of the comment period described in subparagraph (D), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of patient relationship categories and codes.

''(F) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2018), the Secretary shall, through rulemaking, make revisions to the operational list of patient relationship categories and codes as the Secretary determines appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

''(4) REPORTING OF INFORMATION FOR RESOURCE USE MEASUREMENT.—Claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, shall, as determined appropriate by the Secretary, include—

''(A) applicable codes established under paragraphs (2) and (3); and

''(B) the national provider identifier of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner).

''(5) METHODOLOGY FOR RESOURCE USE ANALYSIS.—

''(A) IN GENERAL.—In order to evaluate the resources used to treat patients (with respect to care episode and patient condition groups), the Secretary shall, as the Secretary determines appropriate—

''(i) use the patient relationship codes reported on claims pursuant to paragraph (4) to attribute patients (in whole or in part) to one or more physicians and applicable practitioners;

''(ii) use the care episode and patient condition codes reported on claims pursuant to paragraph (4) as a basis to compare similar patients and care episodes and patient condition groups; and

''(iii) conduct an analysis of resource use (with respect to care episodes and patient condition groups of such patients).

''(B) ANALYSIS OF PATIENTS OF PHYSICIANS AND PRACTITIONERS.—In conducting the analysis described in subparagraph (A)(iii) with respect to patients attributed to physicians and applicable practitioners, the Secretary shall, as feasible—

''(i) use the claims data experience of such patients by patient condition codes during a common period, such as 12 months; and

''(ii) use the claims data experience of such patients by care episode codes—

''(I) in the case of episodes without a hospitalization, during periods of time (such as the number of days) determined appropriate by the Secretary; and

''(II) in the case of episodes with a hospitalization, during periods of time (such as the number of days) before, during, and after the hospitalization.

''(C) MEASUREMENT OF RESOURCE USE.—In measuring such resource use, the Secretary—

''(i) shall use per patient total allowed charges for all services under part A and this part (and, if the Secretary determines appropriate, part D) for the analysis of patient resource use, by care episode codes and by patient condition codes; and

''(ii) may, as determined appropriate, use other measures of allowed charges (such as subtotals for categories of items and services) and measures of utilization of items and services (such as frequency of specific items and services and the ratio of specific items and services among attributed patients or episodes).

''(D) STAKEHOLDER INPUT.—The Secretary shall seek comments from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the resource use methodology established pursuant to this paragraph. In seeking comments the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, web-based forums, or other appropriate mechanisms.

''(6) IMPLEMENTATION.—To the extent that the Secretary contracts with an entity to carry out any part of the provisions of this subsection, the Secretary may not contract with an entity or an entity with a subcontract if the entity or subcontracting entity currently makes recommendations to the Secretary on relative values for services under the fee schedule for physicians' services under this section.

''(7) LIMITATION.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

''(A) care episode and patient condition groups and codes established under paragraph (2);

''(B) patient relationship categories and codes established under paragraph (3); and

''(C) measurement of, and analyses of resource use with respect to, care episode and patient condition codes and patient relationship codes pursuant to paragraph (5).

''(8) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

''(9) DEFINITIONS.—In this subsection:

''(A) PHYSICIAN.—The term 'physician' has the meaning given such term in section 1861(r)(1).

''(B) APPLICABLE PRACTITIONER.—The term 'applicable practitioner' means—

''(i) a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5)), and a certified registered nurse anesthetist (as defined in section 1861(bb)(2)); and

''(ii) beginning January 1, 2019, such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary.

''(10) CLARIFICATION.—The provisions of sections 1890(b)(7) and 1890A shall not apply to this subsection.''.

SEC. 102. PRIORITIES AND FUNDING FOR MEASURE DEVELOPMENT.

Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by subsections (c) and (f) of section 101, is further amended by inserting at the end the following new subsection:

''(s) PRIORITIES AND FUNDING FOR MEASURE DEVELOPMENT.—

''(1) PLAN IDENTIFYING MEASURE DEVELOPMENT PRIORITIES AND TIMELINES.—

''(A) DRAFT MEASURE DEVELOPMENT PLAN.—Not later than January 1, 2016, the Secretary shall develop, and post on the Internet website of the Centers for Medicare & Medicaid Services, a draft plan for the development of quality measures for application under the applicable provisions (as defined in paragraph (5)). Under such plan the Secretary shall—

''(i) address how measures used by private payers and integrated delivery systems could be incorporated under title XVIII;

''(ii) describe how coordination, to the extent possible, will occur across organizations developing such measures; and

''(iii) take into account how clinical best practices and clinical practice guidelines should be used in the development of quality measures.

''(B) QUALITY DOMAINS.—For purposes of this subsection, the term 'quality domains' means at least the following domains:

''(i) Clinical care.

''(ii) Safety.

''(iii) Care coordination.

''(iv) Patient and caregiver experience.

''(v) Population health and prevention.

''(C) CONSIDERATION.—In developing the draft plan under this paragraph, the Secretary shall consider—

''(i) gap analyses conducted by the entity with a contract under section 1890(a) or other contractors or entities;

''(ii) whether measures are applicable across health care settings;

''(iii) clinical practice improvement activities submitted under subsection (q)(2)(C)(iv) for identifying possible areas for future measure development and identifying existing gaps with respect to such measures; and

''(iv) the quality domains applied under this subsection.

''(D) PRIORITIES.—In developing the draft plan under this paragraph, the Secretary shall give priority to the following types of measures:

''(i) Outcome measures, including patient reported outcome and functional status measures.

''(ii) Patient experience measures.

''(iii) Care coordination measures.

''(iv) Measures of appropriate use of services, including measures of over use.

''(E) STAKEHOLDER INPUT.—The Secretary shall accept through March 1, 2016, comments on the draft plan posted under paragraph (1)(A) from the public, including health care providers, payers, consumers, and other stakeholders.

''(F) FINAL MEASURE DEVELOPMENT PLAN.—Not later than May 1, 2016, taking into account the comments received under this subparagraph, the Secretary shall finalize the plan and post on the Internet website of the Centers for Medicare & Medicaid Services an operational plan for the development of quality measures for use under the applicable provisions. Such plan shall be updated as appropriate.

''(2) CONTRACTS AND OTHER ARRANGEMENTS FOR QUALITY MEASURE DEVELOPMENT.—

''(A) IN GENERAL.—The Secretary shall enter into contracts or other arrangements with entities for the purpose of developing, improving, updating, or expanding in accordance with the plan under paragraph (1) quality measures for application under the applicable provisions. Such entities shall include organizations with quality measure development expertise.

''(B) PRIORITIZATION.—

''(i) IN GENERAL.—In entering into contracts or other arrangements under subparagraph (A), the Secretary shall give priority to the development of the types of measures described in paragraph (1)(D).

''(ii) CONSIDERATION.—In selecting measures for development under this subsection, the Secretary shall consider—

''(I) whether such measures would be electronically specified; and

''(II) clinical practice guidelines to the extent that such guidelines exist.

''(3) ANNUAL REPORT BY THE SECRETARY.—

''(A) IN GENERAL.—Not later than May 1, 2017, and annually thereafter, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a report on the progress made in developing quality measures for application under the applicable provisions.

''(B) REQUIREMENTS.—Each report submitted pursuant to subparagraph (A) shall include the following:

''(i) A description of the Secretary's efforts to implement this paragraph.

''(ii) With respect to the measures developed during the previous year—

''(I) a description of the total number of quality measures developed and the types of such measures, such as an outcome or patient experience measure;

''(II) the name of each measure developed;

''(III) the name of the developer and steward of each measure;

''(IV) with respect to each type of measure, an estimate of the total amount expended under this title to develop all measures of such type; and

''(V) whether the measure would be electronically specified.

''(iii) With respect to measures in development at the time of the report—

''(I) the information described in clause (ii), if available; and

''(II) a timeline for completion of the development of such measures.

''(iv) A description of any updates to the plan under paragraph (1) (including newly identified gaps and the status of previously identified gaps) and the inventory of measures applicable under the applicable provisions.

''(v) Other information the Secretary determines to be appropriate.

''(4) STAKEHOLDER INPUT.—With respect to paragraph (1), the Secretary shall seek stakeholder input with respect to—

''(A) the identification of gaps where no quality measures exist, particularly with respect to the types of measures described in paragraph (1)(D);

''(B) prioritizing quality measure development to address such gaps; and

''(C) other areas related to quality measure development determined appropriate by the Secretary.

''(5) DEFINITION OF APPLICABLE PROVISIONS.—In this subsection, the term 'applicable provisions' means the following provisions:

''(A) Subsection (q)(2)(B)(i).

''(B) Section 1833(z)(2)(C).

''(6) FUNDING.—For purposes of carrying out this subsection, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2015 through 2019. Amounts transferred under this paragraph shall remain available through the end of fiscal year 2022.

''(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the collection of information for the development of quality measures.''.

SEC. 103. ENCOURAGING CARE MANAGEMENT FOR INDIVIDUALS WITH CHRONIC CARE NEEDS.

(a) IN GENERAL.—Section 1848(b) of the Social Security Act (42 U.S.C. 1395w–4(b)) is amended by adding at the end the following new paragraph:

''(8) ENCOURAGING CARE MANAGEMENT FOR INDIVIDUALS WITH CHRONIC CARE NEEDS.—

''(A) IN GENERAL.—In order to encourage the management of care for individuals with chronic care needs the Secretary shall, subject to subparagraph (B), make payment (as the Secretary determines to be appropriate) under this section for chronic care management services furnished on or after January 1, 2015, by a physician (as defined in section 1861(r)(1)), physician assistant or nurse practitioner (as defined in section 1861(aa)(5)(A)), clinical nurse specialist (as defined in section 1861(aa)(5)(B)), or certified nurse midwife (as defined in section 1861(gg)(2)).

''(B) POLICIES RELATING TO PAYMENT.—In carrying out this paragraph, with respect to chronic care management services, the Secretary shall—

''(i) make payment to only one applicable provider for such services furnished to an individual during a period;

''(ii) not make payment under subparagraph (A) if such payment would be duplicative of payment that is otherwise made under this title for such services; and

''(iii) not require that an annual wellness visit (as defined in section 1861(hhh)) or an initial preventive physical examination (as defined in section 1861(ww)) be furnished as a condition of payment for such management services.''.

(b) EDUCATION AND OUTREACH.—

(1) CAMPAIGN.—

(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall conduct an education and outreach campaign to inform professionals who furnish items and services under part B of title XVIII of the Social Security Act and individuals enrolled under such part of the benefits of chronic care management services described in section 1848(b)(8) of the Social Security Act, as added by subsection (a), and encourage such individuals with chronic care needs to receive such services.

(B) REQUIREMENTS.—Such campaign shall—

(i) be directed by the Office of Rural Health Policy of the Department of Health and Human Services and the Office of Minority Health of the Centers for Medicare & Medicaid Services; and

(ii) focus on encouraging participation by underserved rural populations and racial and ethnic minority populations.

(2) REPORT.—Not later than December 31, 2017, the Secretary shall submit to Congress a report on the use of chronic care management services described in such section 1848(b)(8) by individuals living in rural areas and by racial and ethnic minority populations. Such report shall—

(A) identify barriers to receiving chronic care management services; and

(B) make recommendations for increasing the appropriate use of chronic care management services.

SEC. 104. EMPOWERING BENEFICIARY CHOICES THROUGH CONTINUED ACCESS TO INFORMATION ON PHYSICIANS' SERVICES.

(a) IN GENERAL.—On an annual basis (beginning with 2015), the Secretary shall make publicly available, in an easily understandable format, information with respect to physicians and, as appropriate, other eligible professionals on items and services furnished to Medicare beneficiaries under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) TYPE AND MANNER OF INFORMATION.—The information made available under this section shall be similar to the type of information in the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File released by the Secretary with respect to 2012 and shall be made available in a manner similar to the manner in which the information in such file is made available.

(c) REQUIREMENTS.—The information made available under this section shall include, at a minimum, the following:

(1) Information on the number of services furnished by the physician or other eligible professional under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.), which may include information on the most frequent services furnished or groupings of services.

(2) Information on submitted charges and payments for services under such part.

(3) A unique identifier for the physician or other eligible professional that is available to the public, such as a national provider identifier.

(d) SEARCHABILITY.—The information made available under this section shall be searchable by at least the following:

(1) The specialty or type of the physician or other eligible professional.

(2) Characteristics of the services furnished, such as volume or groupings of services.

(3) The location of the physician or other eligible professional.

(e) INTEGRATION ON PHYSICIAN COMPARE.—Beginning with 2016, the Secretary shall integrate the information made available under this section on Physician Compare.

(f) DEFINITIONS.—In this section:

(1) ELIGIBLE PROFESSIONAL; PHYSICIAN; SECRETARY.—The terms ''eligible professional'', ''physician'', and ''Secretary'' have the meaning given such terms in section 10331(i) of Public Law 111–148.

(2) PHYSICIAN COMPARE.—The term ''Physician Compare'' means the Physician Compare Internet website of the Centers for Medicare & Medicaid Services (or a successor website).

SEC. 105. EXPANDING AVAILABILITY OF MEDICARE DATA.

(a) EXPANDING USES OF MEDICARE DATA BY QUALIFIED ENTITIES.—

(1) ADDITIONAL ANALYSES.—

(A) IN GENERAL.—Subject to subparagraph (B), to the extent consistent with applicable information, privacy, security, and disclosure laws (including paragraph (3)), notwithstanding paragraph (4)(B) of section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) and the second sentence of paragraph (4)(D) of such section, beginning July 1, 2016, a qualified entity may use the combined data described in paragraph (4)(B)(iii) of such section received by such entity under such section, and information derived from the evaluation described in such paragraph (4)(D), to conduct additional non-public analyses (as determined appropriate by the Secretary) and provide or sell such analyses to authorized users for non-public use (including for the purposes of assisting providers of services and suppliers to develop and participate in quality and patient care improvement activities, including developing new models of care).

(B) LIMITATIONS WITH RESPECT TO ANALYSES.—

(i) EMPLOYERS.—Any analyses provided or sold under subparagraph (A) to an employer described in paragraph (9)(A)(iii) may only be used by such employer for purposes of providing health insurance to employees and retirees of the employer.

(ii) HEALTH INSURANCE ISSUERS.—A qualified entity may not provide or sell an analysis to a health insurance issuer described in paragraph (9)(A)(iv) unless the issuer is providing the qualified entity with data under section 1874(e)(4)(B)(iii) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(B)(iii)).

(2) ACCESS TO CERTAIN DATA.—

(A) ACCESS.—To the extent consistent with applicable information, privacy, security, and disclosure laws (including paragraph (3)), notwithstanding paragraph (4)(B) of section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) and the second sentence of paragraph (4)(D) of such section, beginning July 1, 2016, a qualified entity may—

(i) provide or sell the combined data described in paragraph (4)(B)(iii) of such section to authorized users described in clauses (i), (ii), and (v) of paragraph (9)(A) for non-public use, including for the purposes described in subparagraph (B); or

(ii) subject to subparagraph (C), provide Medicare claims data to authorized users described in clauses (i), (ii), and (v), of paragraph (9)(A) for non-public use, including for the purposes described in subparagraph (B).

(B) PURPOSES DESCRIBED.—The purposes described in this subparagraph are assisting providers of services and suppliers in developing and participating in quality and patient care improvement activities, including developing new models of care.

(C) MEDICARE CLAIMS DATA MUST BE PROVIDED AT NO COST.—A qualified entity may not charge a fee for providing the data under subparagraph (A)(ii).

(3) PROTECTION OF INFORMATION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an analysis or data that is provided or sold under paragraph (1) or (2) shall not contain information that individually identifies a patient.

(B) INFORMATION ON PATIENTS OF THE PROVIDER OF SERVICES OR SUPPLIER.—To the extent consistent with applicable information, privacy, security, and disclosure laws, an analysis or data that is provided or sold to a provider of services or supplier under paragraph (1) or (2) may contain information that individually identifies a patient of such provider or supplier, including with respect to items and services furnished to the patient by other providers of services or suppliers.

(C) PROHIBITION ON USING ANALYSES OR DATA FOR MARKETING PURPOSES.—An authorized user shall not use an analysis or data provided or sold under paragraph (1) or (2) for marketing purposes.

(4) DATA USE AGREEMENT.—A qualified entity and an authorized user described in clauses (i), (ii), and (v) of paragraph (9)(A) shall enter into an agreement regarding the use of any data that the qualified entity is providing or selling to the authorized user under paragraph (2). Such agreement shall describe the requirements for privacy and security of the data and, as determined appropriate by the Secretary, any prohibitions on using such data to link to other individually identifiable sources of information. If the authorized user is not a covered entity under the rules promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, the agreement shall identify the relevant regulations, as determined by the Secretary, that the user shall comply with as if it were acting in the capacity of such a covered entity.

(5) NO REDISCLOSURE OF ANALYSES OR DATA.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an authorized user that is provided or sold an analysis or data under paragraph (1) or (2) shall not redisclose or make public such analysis or data or any analysis using such data.

(B) PERMITTED REDISCLOSURE.—A provider of services or supplier that is provided or sold an analysis or data under paragraph (1) or (2) may, as determined by the Secretary, redisclose such analysis or data for the purposes of performance improvement and care coordination activities but shall not make public such analysis or data or any analysis using such data.

(6) OPPORTUNITY FOR PROVIDERS OF SERVICES AND SUPPLIERS TO REVIEW.—Prior to a qualified entity providing or selling an analysis to an authorized user under paragraph (1), to the extent that such analysis would individually identify a provider of services or supplier who is not being provided or sold such analysis, such qualified entity shall provide such provider or supplier with the opportunity to appeal and correct errors in the manner described in section 1874(e)(4)(C)(ii) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(C)(ii)).

(7) ASSESSMENT FOR A BREACH.—

(A) IN GENERAL.—In the case of a breach of a data use agreement under this section or section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)), the Secretary shall impose an assessment on the qualified entity both in the case of—

(i) an agreement between the Secretary and a qualified entity; and

(ii) an agreement between a qualified entity and an authorized user.

(B) ASSESSMENT.—The assessment under subparagraph (A) shall be an amount up to $100 for each individual entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act or enrolled for benefits under part B of such title—

(i) in the case of an agreement described in subparagraph (A)(i), for whom the Secretary provided data on to the qualified entity under paragraph (2); and

(ii) in the case of an agreement described in subparagraph (A)(ii), for whom the qualified entity provided data on to the authorized user under paragraph (2).

(C) DEPOSIT OF AMOUNTS COLLECTED.—Any amounts collected pursuant to this paragraph shall be deposited in Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t).

(8) ANNUAL REPORTS.—Any qualified entity that provides or sells an analysis or data under paragraph (1) or (2) shall annually submit to the Secretary a report that includes—

(A) a summary of the analyses provided or sold, including the number of such analyses, the number of purchasers of such analyses, and the total amount of fees received for such analyses;

(B) a description of the topics and purposes of such analyses;

(C) information on the entities who received the data under paragraph (2), the uses of the data, and the total amount of fees received for providing, selling, or sharing the data; and

(D) other information determined appropriate by the Secretary.

(9) DEFINITIONS.—In this subsection and subsection (b):

(A) AUTHORIZED USER.—The term ''authorized user'' means the following:

(i) A provider of services.

(ii) A supplier.

(iii) An employer (as defined in section 3(5) of the Employee Retirement Insurance Security Act of 1974).

(iv) A health insurance issuer (as defined in section 2791 of the Public Health Service Act).

(v) A medical society or hospital association.

(vi) Any entity not described in clauses (i) through (v) that is approved by the Secretary (other than an employer or health insurance issuer not described in clauses (iii) and (iv), respectively, as determined by the Secretary).

(B) PROVIDER OF SERVICES.—The term ''provider of services'' has the meaning given such term in section 1861(u) of the Social Security Act (42 U.S.C. 1395x(u)).

(C) QUALIFIED ENTITY.—The term ''qualified entity'' has the meaning given such term in section 1874(e)(2) of the Social Security Act (42 U.S.C. 1395kk(e)).

(D) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(E) SUPPLIER.—The term ''supplier'' has the meaning given such term in section 1861(d) of the Social Security Act (42 U.S.C. 1395x(d)).

(b) ACCESS TO MEDICARE DATA BY QUALIFIED CLINICAL DATA REGISTRIES TO FACILITATE QUALITY IMPROVEMENT.—

(1) ACCESS.—

(A) IN GENERAL.—To the extent consistent with applicable information, privacy, security, and disclosure laws, beginning July 1, 2016, the Secretary shall, at the request of a qualified clinical data registry under section 1848(m)(3)(E) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(E)), provide the data described in subparagraph (B) (in a form and manner determined to be appropriate) to such qualified clinical data registry for purposes of linking such data with clinical outcomes data and performing risk-adjusted, scientifically valid analyses and research to support quality improvement or patient safety, provided that any public reporting of such analyses or research that identifies a provider of services or supplier shall only be conducted with the opportunity of such provider or supplier to appeal and correct errors in the manner described in subsection (a)(6).

(B) DATA DESCRIBED.—The data described in this subparagraph is—

(i) claims data under the Medicare program under title XVIII of the Social Security Act; and

(ii) if the Secretary determines appropriate, claims data under the Medicaid program under title XIX of such Act and the State Children's Health Insurance Program under title XXI of such Act.

(2) FEE.—Data described in paragraph (1)(B) shall be provided to a qualified clinical data registry under paragraph (1) at a fee equal to the cost of providing such data. Any fee collected pursuant to the preceding sentence shall be deposited in the Centers for Medicare & Medicaid Services Program Management Account.

(c) EXPANSION OF DATA AVAILABLE TO QUALIFIED ENTITIES.—Section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) is amended—

(1) in the subsection heading, by striking ''MEDICARE''; and

(2) in paragraph (3)—

(A) by inserting after the first sentence the following new sentence: ''Beginning July 1, 2016, if the Secretary determines appropriate, the data described in this paragraph may also include standardized extracts (as determined by the Secretary) of claims data under titles XIX and XXI for assistance provided under such titles for one or more specified geographic areas and time periods requested by a qualified entity.''; and

(B) in the last sentence, by inserting ''or under titles XIX or XXI'' before the period at the end.

(d) REVISION OF PLACEMENT OF FEES.—Section 1874(e)(4)(A) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(A)) is amended, in the second sentence—

(1) by inserting '', for periods prior to July 1, 2016,'' after ''deposited''; and

(2) by inserting the following before the period at the end: '', and, beginning July 1, 2016, into the Centers for Medicare & Medicaid Services Program Management Account''.

SEC. 106. REDUCING ADMINISTRATIVE BURDEN AND OTHER PROVISIONS.

(a) MEDICARE PHYSICIAN AND PRACTITIONER OPT-OUT TO PRIVATE CONTRACT.—

(1) INDEFINITE, CONTINUING AUTOMATIC EXTENSION OF OPT OUT ELECTION.—

(A) IN GENERAL.—Section 1802(b)(3) of the Social Security Act (42 U.S.C. 1395a(b)(3)) is amended—

(i) in subparagraph (B)(ii), by striking ''during the 2-year period beginning on the date the affidavit is signed'' and inserting ''during the applicable 2-year period (as defined in subparagraph (D))'';

(ii) in subparagraph (C), by striking ''during the 2-year period described in subparagraph (B)(ii)'' and inserting ''during the applicable 2-year period''; and

(iii) by adding at the end the following new subparagraph:

''(D) APPLICABLE 2-YEAR PERIODS FOR EFFECTIVENESS OF AFFIDAVITS.—In this subsection, the term 'applicable 2-year period' means, with respect to an affidavit of a physician or practitioner under subparagraph (B), the 2-year period beginning on the date the affidavit is signed and includes each subsequent 2-year period unless the physician or practitioner involved provides notice to the Secretary (in a form and manner specified by the Secretary), not later than 30 days before the end of the previous 2-year period, that the physician or practitioner does not want to extend the application of the affidavit for such subsequent 2-year period.''.

(B) EFFECTIVE DATE.—The amendments made by subparagraph (A) shall apply to affidavits entered into on or after the date that is 60 days after the date of the enactment of this Act.

(2) PUBLIC AVAILABILITY OF INFORMATION ON OPT-OUT PHYSICIANS AND PRACTITIONERS.—Section 1802(b) of the Social Security Act (42 U.S.C. 1395a(b)) is amended—

(A) in paragraph (5), by adding at the end the following new subparagraph:

''(D) OPT-OUT PHYSICIAN OR PRACTITIONER.—The term 'opt-out physician or practitioner' means a physician or practitioner who has in effect an affidavit under paragraph (3)(B).'';

(B) by redesignating paragraph (5) as paragraph (6); and

(C) by inserting after paragraph (4) the following new paragraph:

''(5) POSTING OF INFORMATION ON OPT-OUT PHYSICIANS AND PRACTITIONERS.—

''(A) IN GENERAL.—Beginning not later than February 1, 2016, the Secretary shall make publicly available through an appropriate publicly accessible website of the Department of Health and Human Services information on the number and characteristics of opt-out physicians and practitioners and shall update such information on such website not less often than annually.

''(B) INFORMATION TO BE INCLUDED.—The information to be made available under subparagraph (A) shall include at least the following with respect to opt-out physicians and practitioners:

''(i) Their number.

''(ii) Their physician or professional specialty or other designation.

''(iii) Their geographic distribution.

''(iv) The timing of their becoming opt-out physicians and practitioners, relative, to the extent feasible, to when they first enrolled in the program under this title and with respect to applicable 2-year periods.

''(v) The proportion of such physicians and practitioners who billed for emergency or urgent care services.''.

(b) PROMOTING INTEROPERABILITY OF ELECTRONIC HEALTH RECORD SYSTEMS.—

(1) RECOMMENDATIONS FOR ACHIEVING WIDESPREAD EHR INTEROPERABILITY.—

(A) OBJECTIVE.—As a consequence of a significant Federal investment in the implementation of health information technology through the Medicare and Medicaid EHR incentive programs, Congress declares it a national objective to achieve widespread exchange of health information through interoperable certified EHR technology nationwide by December 31, 2018.

(B) DEFINITIONS.—In this paragraph:

(i) WIDESPREAD INTEROPERABILITY.—The term ''widespread interoperability'' means interoperability between certified EHR technology systems employed by meaningful EHR users under the Medicare and Medicaid EHR incentive programs and other clinicians and health care providers on a nationwide basis.

(ii) INTEROPERABILITY.—The term ''interoperability'' means the ability of two or more health information systems or components to exchange clinical and other information and to use the information that has been exchanged using common standards as to provide access to longitudinal information for health care providers in order to facilitate coordinated care and improved patient outcomes.

(C) ESTABLISHMENT OF METRICS.—Not later than July 1, 2016, and in consultation with stakeholders, the Secretary shall establish metrics to be used to determine if and to the extent that the objective described in subparagraph (A) has been achieved.

(D) RECOMMENDATIONS IF OBJECTIVE NOT ACHIEVED.—If the Secretary of Health and Human Services determines that the objective described in subparagraph (A) has not been achieved by December 31, 2018, then the Secretary shall submit to Congress a report, by not later than December 31, 2019, that identifies barriers to such objective and recommends actions that the Federal Government can take to achieve such objective. Such recommended actions may include recommendations—

(i) to adjust payments for not being meaningful EHR users under the Medicare EHR incentive programs; and

(ii) for criteria for decertifying certified EHR technology products.

(2) PREVENTING BLOCKING THE SHARING OF INFORMATION.—

(A) FOR MEANINGFUL USE EHR PROFESSIONALS.—Section 1848(o)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)(A)(ii)) is amended by inserting before the period at the end the following: '', and the professional demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the professional has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology''.

(B) FOR MEANINGFUL USE EHR HOSPITALS.—Section 1886(n)(3)(A)(ii) of the Social Security Act (42 U.S.C. 1395ww(n)(3)(A)(ii)) is amended by inserting before the period at the end the following: '', and the hospital demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the hospital has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology''.

(C) EFFECTIVE DATE.—The amendments made by this subsection shall apply to meaningful EHR users as of the date that is one year after the date of the enactment of this Act.

(3) STUDY AND REPORT ON THE FEASIBILITY OF ESTABLISHING A MECHANISM TO COMPARE CERTIFIED EHR TECHNOLOGY PRODUCTS.—

(A) STUDY.—The Secretary shall conduct a study to examine the feasibility of establishing one or more mechanisms to assist providers in comparing and selecting certified EHR technology products. Such mechanisms may include—

(i) a website with aggregated results of surveys of meaningful EHR users on the functionality of certified EHR technology products to enable such users to directly compare the functionality and other features of such products; and

(ii) information from vendors of certified products that is made publicly available in a standardized format.

The aggregated results of the surveys described in clause (i) may be made available through contracts with physicians, hospitals, or other organizations that maintain such comparative information described in such clause.

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on mechanisms that would assist providers in comparing and selecting certified EHR technology products. The report shall include information on the benefits of, and resources needed to develop and maintain, such mechanisms.

(4) DEFINITIONS.—In this subsection:

(A) The term ''certified EHR technology'' has the meaning given such term in section 1848(o)(4) of the Social Security Act (42 U.S.C. 1395w–4(o)(4)).

(B) The term ''meaningful EHR user'' has the meaning given such term under the Medicare EHR incentive programs.

(C) The term ''Medicare and Medicaid EHR incentive programs'' means—

(i) in the case of the Medicare program under title XVIII of the Social Security Act, the incentive programs under section 1814(l)(3), section 1848(o), subsections (l) and (m) of section 1853, and section 1886(n) of the Social Security Act (42 U.S.C. 1395f(l)(3), 1395w–4(o), 1395w–23, 1395ww(n)); and

(ii) in the case of the Medicaid program under title XIX of such Act, the incentive program under subsections (a)(3)(F) and (t) of section 1903 of such Act (42 U.S.C. 1396b).

(D) The term ''Secretary'' means the Secretary of Health and Human Services.

(c) GAO STUDIES AND REPORTS ON THE USE OF TELEHEALTH UNDER FEDERAL PROGRAMS AND ON REMOTE PATIENT MONITORING SERVICES.—

(1) STUDY ON TELEHEALTH SERVICES.—The Comptroller General of the United States shall conduct a study on the following:

(A) How the definition of telehealth across various Federal programs and Federal efforts can inform the use of telehealth in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(B) Issues that can facilitate or inhibit the use of telehealth under the Medicare program under such title, including oversight and professional licensure, changing technology, privacy and security, infrastructure requirements, and varying needs across urban and rural areas.

(C) Potential implications of greater use of telehealth with respect to payment and delivery system transformations under the Medicare program under such title XVIII and the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.).

(D) How the Centers for Medicare & Medicaid Services monitors payments made under the Medicare program under such title XVIII to providers for telehealth services.

(2) STUDY ON REMOTE PATIENT MONITORING SERVICES.—

(A) IN GENERAL.—The Comptroller General of the United States shall conduct a study—

(i) of the dissemination of remote patient monitoring technology in the private health insurance market;

(ii) of the financial incentives in the private health insurance market relating to adoption of such technology;

(iii) of the barriers to adoption of such services under the Medicare program under title XVIII of the Social Security Act;

(iv) that evaluates the patients, conditions, and clinical circumstances that could most benefit from remote patient monitoring services; and

(v) that evaluates the challenges related to establishing appropriate valuation for remote patient monitoring services under the Medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) in order to accurately reflect the resources involved in furnishing such services.

(B) DEFINITIONS.—For purposes of this paragraph:

(i) REMOTE PATIENT MONITORING SERVICES.—The term ''remote patient monitoring services'' means services furnished through remote patient monitoring technology.

(ii) REMOTE PATIENT MONITORING TECHNOLOGY.—The term ''remote patient monitoring technology'' means a coordinated system that uses one or more home-based or mobile monitoring devices that automatically transmit vital sign data or information on activities of daily living and may include responses to assessment questions collected on the devices wirelessly or through a telecommunications connection to a server that complies with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, as part of an established plan of care for that patient that includes the review and interpretation of that data by a health care professional.

(3) REPORTS.—Not later than 24 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress—

(A) a report containing the results of the study conducted under paragraph (1); and

(B) a report containing the results of the study conducted under paragraph (2).

A report required under this paragraph shall be submitted together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate. The Comptroller General may submit one report containing the results described in subparagraphs (A) and (B) and the recommendations described in the previous sentence.

(d) RULE OF CONSTRUCTION REGARDING HEALTH CARE PROVIDERS.—

(1) IN GENERAL.—Subject to paragraph (3), the development, recognition, or implementation of any guideline or other standard under any Federal health care provision shall not be construed to establish the standard of care or duty of care owed by a health care provider to a patient in any medical malpractice or medical product liability action or claim.

(2) DEFINITIONS.—For purposes of this subsection:

(A) FEDERAL HEALTH CARE PROVISION.—The term ''Federal health care provision'' means any provision of the Patient Protection and Affordable Care Act (Public Law 111–148), title I or subtitle B of title II of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), or title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq., 42 U.S.C. 1396 et seq.).

(B) HEALTH CARE PROVIDER.—The term ''health care provider'' means any individual, group practice, corporation of health care professionals, or hospital—

(i) licensed, registered, or certified under Federal or State laws or regulations to provide health care services; or

(ii) required to be so licensed, registered, or certified but that is exempted by other statute or regulation.

(C) MEDICAL MALPRACTICE OR MEDICAL PRODUCT LIABILITY ACTION OR CLAIM.—The term ''medical malpractice or medical product liability action or claim'' means a medical malpractice action or claim (as defined in section 431(7) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11151(7))) and includes a liability action or claim relating to a health care provider's prescription or provision of a drug, device, or biological product (as such terms are defined in section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321) or section 351 of the Public Health Service Act (42 U.S.C. 262)).

(D) STATE.—The term ''State'' includes the District of Columbia, Puerto Rico, and any other commonwealth, possession, or territory of the United States.

(3) NO PREEMPTION.—Nothing in paragraph (1) or any provision of the Patient Protection and Affordable Care Act (Public Law 111–148), title I or subtitle B of title II of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), or title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq., 42 U.S.C. 1396 et seq.) shall be construed to preempt any State or common law governing medical professional or medical product liability actions or claims.

TITLE II—MEDICARE AND OTHER HEALTH EXTENDERS

Subtitle A—Medicare Extenders

SEC. 201. EXTENSION OF WORK GPCI FLOOR.

Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended by striking ''April 1, 2015'' and inserting ''January 1, 2018''.

SEC. 202. EXTENSION OF THERAPY CAP EXCEPTIONS PROCESS.

(a) IN GENERAL.—Section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) is amended—

(1) in paragraph (5)(A), in the first sentence, by striking ''March 31, 2015'' and inserting ''December 31, 2017''; and

(2) in paragraph (6)(A)—

(A) by striking ''March 31, 2015'' and inserting ''December 31, 2017''; and

(B) by striking ''2012, 2013, 2014, or the first three months of 2015'' and inserting ''2012 through 2017''.

(b) TARGETED REVIEWS UNDER MANUAL MEDICAL REVIEW PROCESS FOR OUTPATIENT THERAPY SERVICES.—

(1) IN GENERAL.—Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)) is amended—

(A) in subparagraph (C)(i), by inserting '', subject to subparagraph (E),'' after ''manual medical review process that''; and

(B) by adding at the end the following new subparagraph:

''(E)(i) In place of the manual medical review process under subparagraph (C)(i), the Secretary shall implement a process for medical review under this subparagraph under which the Secretary shall identify and conduct medical review for services described in subparagraph (C)(i) furnished by a provider of services or supplier (in this subparagraph referred to as a 'therapy provider') using such factors as the Secretary determines to be appropriate.

''(ii) Such factors may include the following:

''(I) The therapy provider has had a high claims denial percentage for therapy services under this part or is less compliant with applicable requirements under this title.

''(II) The therapy provider has a pattern of billing for therapy services under this part that is aberrant compared to peers or otherwise has questionable billing practices for such services, such as billing medically unlikely units of services in a day.

''(III) The therapy provider is newly enrolled under this title or has not previously furnished therapy services under this part.

''(IV) The services are furnished to treat a type of medical condition.

''(V) The therapy provider is part of group that includes another therapy provider identified using the factors determined under this subparagraph.

''(iii) For purposes of carrying out this subparagraph, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal years 2015 and 2016, to remain available until expended. Such funds may not be used by a contractor

under section 1893(h) for medical reviews under this subparagraph.

''(iv) The targeted review process under this subparagraph shall not apply to services for which expenses are incurred beyond the period for which the exceptions process under subparagraph (A) is implemented.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to requests described in section 1833(g)(5)(C)(i) of the Social Security Act (42 U.S.C. 1395l(g)(5)(C)(i)) with respect to which the Secretary of Health and Human Services has not conducted medical review under such section by a date (not later than 90 days after the date of the enactment of this Act) specified by the Secretary.

SEC. 203. EXTENSION OF AMBULANCE ADD-ONS.

(a) GROUND AMBULANCE.—Section 1834(l)(13)(A) of the Social Security Act (42 U.S.C. 1395m(l)(13)(A)) is amended by striking ''April 1, 2015'' and inserting ''January 1, 2018'' each place it appears.

(b) SUPER RURAL GROUND AMBULANCE.—Section 1834(l)(12)(A) of the Social Security Act (42 U.S.C. 1395m(l)(12)(A)) is amended, in the first sentence, by striking ''April 1, 2015'' and inserting ''January 1, 2018''.

SEC. 204. EXTENSION OF INCREASED INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR CERTAIN LOW-VOLUME HOSPITALS.

Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

(1) in subparagraph (B), in the matter preceding clause (i), by striking ''in fiscal year 2015 (beginning on April 1, 2015), fiscal year 2016, and subsequent fiscal years'' and inserting ''in fiscal year 2018 and subsequent fiscal years'';

(2) in subparagraph (C)(i), by striking ''fiscal years 2011 through 2014 and fiscal year 2015 (before April 1, 2015),'' and inserting ''fiscal years 2011 through 2017,'' each place it appears; and

(3) in subparagraph (D), by striking ''fiscal years 2011 through 2014 and fiscal year 2015 (before April 1, 2015),'' and inserting ''fiscal years 2011 through 2017,''.

SEC. 205. EXTENSION OF THE MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM.

(a) IN GENERAL.—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(1) in clause (i), by striking ''April 1, 2015'' and inserting ''October 1, 2017''; and

(2) in clause (ii)(II), by striking ''April 1, 2015'' and inserting ''October 1, 2017''.

(b) CONFORMING AMENDMENTS.—

(1) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking ''April 1, 2015'' and inserting ''October 1, 2017''; and

(B) in clause (iv), by striking ''through fiscal year 2014 and the portion of fiscal year 2015 before April 1, 2015'' and inserting ''through fiscal year 2017''.

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note) is amended by striking ''through the first 2 quarters of fiscal year 2015'' and inserting ''through fiscal year 2017''.

SEC. 206. EXTENSION FOR SPECIALIZED MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS INDIVIDUALS.

Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)) is amended by striking ''2017'' and inserting ''2019''.

SEC. 207. EXTENSION OF FUNDING FOR QUALITY MEASURE ENDORSEMENT, INPUT, AND SELECTION.

Section 1890(d)(2) of the Social Security Act (42 U.S.C. 1395aaa(d)(2)) is amended by striking ''and $15,000,000 for the first 6 months of fiscal year 2015'' and inserting ''and $30,000,000 for each of fiscal years 2015 through 2017''.

SEC. 208. EXTENSION OF FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.

(a) ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE PROGRAMS.—Subsection (a)(1)(B) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note), as amended by section 3306 of the Patient Protection and Affordable Care Act (Public Law 111–148), section 610 of the American Taxpayer Relief Act of 2012 (Public Law 112–240), section 1110 of the Pathway for SGR Reform Act of 2013 (Public Law 113–67), and section 110 of the Protecting Access to Medicare Act of 2014 (Public Law 113–93), is amended—

(1) in clause (iv), by striking ''and'' at the end;

(2) by striking clause (v); and

(3) by adding at the end the following new clauses:

''(v) for fiscal year 2015, of $7,500,000;

''(vi) for fiscal year 2016, of $13,000,000; and

''(vii) for fiscal year 2017, of $13,000,000.''.

(b) ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.—Subsection (b)(1)(B) of such section 119, as so amended, is amended—

(1) in clause (iv), by striking ''and'' at the end;

(2) by striking clause (v); and

(3) by inserting after clause (iv) the following new clauses:

''(v) for fiscal year 2015, of $7,500,000;

''(vi) for fiscal year 2016, of $7,500,000; and

''(vii) for fiscal year 2017, of $7,500,000.''.

(c) ADDITIONAL FUNDING FOR AGING AND DISABILITY RESOURCE CENTERS.—Subsection (c)(1)(B) of such section 119, as so amended, is amended—

(1) in clause (iv), by striking ''and'' at the end;

(2) by striking clause (v); and

(3) by inserting after clause (iv) the following new clauses:

''(v) for fiscal year 2015, of $5,000,000;

''(vi) for fiscal year 2016, of $5,000,000; and

''(vii) for fiscal year 2017, of $5,000,000.''.

(d) ADDITIONAL FUNDING FOR CONTRACT WITH THE NATIONAL CENTER FOR BENEFITS AND OUTREACH ENROLLMENT.—Subsection (d)(2) of such section 119, as so amended, is amended—

(1) in clause (iv), by striking ''and'' at the end;

(2) by striking clause (v); and

(3) by inserting after clause (iv) the following new clauses:

''(v) for fiscal year 2015, of $5,000,000;

''(vi) for fiscal year 2016, of $12,000,000; and

''(vii) for fiscal year 2017, of $12,000,000.''.

SEC. 209. EXTENSION AND TRANSITION OF REASONABLE COST REIMBURSEMENT CONTRACTS.

(a) ONE-YEAR TRANSITION AND NOTICE REGARDING TRANSITION.—Section 1876(h)(5)(C) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)) is amended—

(1) in clause (ii), in the matter preceding subclause (I), by striking ''For any'' and inserting ''Subject to clause (iv), for any'';

(2) in clause (iii)(I), by inserting ''cost plan service'' after ''With respect to any portion of the'';

(3) in clause (iii)(II), by inserting ''cost plan service'' after ''With respect to any other portion of such''; and

(4) by adding at the end the following new clauses:

''(iv) In the case of an eligible organization that is offering a reasonable cost reimbursement contract that may no longer be extended or renewed because of the application of clause (ii), or where such contract has been extended or renewed but the eligible organization has informed the Secretary in writing not later than a date determined appropriate by the Secretary that such organization voluntarily plans not to seek renewal of the reasonable cost reimbursement contract, the following shall apply:

''(I) Notwithstanding such clause, such contract may be extended or renewed for the two years subsequent to 2016. The final year in which such contract is extended or renewed is referred to in this subsection as the 'last reasonable cost reimbursement contract year for the contract'.

''(II) The organization may not enroll a new enrollee under such contract during the last reasonable cost reimbursement contract year for the contract (but may continue to enroll new enrollees through the end of the year immediately preceding such year) unless such enrollee is any of the following:

''(aa) An individual who chooses enrollment in the reasonable cost contract during the annual election period with respect to such last year.

''(bb) An individual whose spouse, at the time of the individual's enrollment is an enrollee under the reasonable cost reimbursement contract.

''(cc) An individual who is covered under an employer group health plan that offers coverage through the reasonable cost reimbursement contract.

''(dd) An individual who becomes entitled to benefits under part A, or enrolled under part B, and was enrolled in a plan offered by the eligible organization immediately prior to the individual's enrollment under the reasonable cost reimbursement contract.

''(III) Not later than a date determined appropriate by the Secretary prior to the beginning of the last reasonable cost reimbursement contract year for the contract, the organization shall provide notice to the Secretary as to whether the organization will apply to have the contract converted over, in whole or in part, and offered as a Medicare Advantage plan under part C for the year following the last reasonable cost reimbursement contract year for the contract.

''(IV) If the organization provides the notice described in subclause (III) that the contract will be converted, in whole or in part, the organization shall, not later than a date determined appropriate by the Secretary, provide the Secretary with such information as the Secretary determines appropriate in order to carry out section 1851(c)(4) and to carry out section 1854(a)(5), including subparagraph (C)(ii) of such section.

''(V) In the case that the organization enrolls a new enrollee under such contract during the last reasonable cost reimbursement contract year for the contract, the organization shall provide the individual with a notification that such year is the last year for such contract.

''(v) If an eligible organization that is offering a reasonable cost reimbursement contract that is extended or renewed pursuant to clause (iv) provides the notice described in clause (iv)(III) that the contract will be converted, in whole or in part, the following shall apply:

''(I) The deemed enrollment under section 1851(c)(4).

''(II) The special rule for quality increase under section 1853(o)(4)(C).

''(III) During the last reasonable cost reimbursement contract year for the contract and the year immediately preceding such year, the eligible organization, or the corporate parent organization of the eligible organization, shall be permitted to offer an MA plan in the area that such contract is being offered and enroll Medicare Advantage eligible individuals in such MA plan and such cost plan.''.

(b) DEEMED ENROLLMENT FROM REASONABLE COST REIMBURSEMENT CONTRACTS CONVERTED TO MEDICARE ADVANTAGE PLANS.—

(1) IN GENERAL.—Section 1851(c) of the Social Security Act (42 U.S.C. 1395w–21(c)) is amended—

(A) in paragraph (1), by striking ''Such elections'' and inserting ''Subject to paragraph (4), such elections''; and

(B) by adding at the end the following:

''(4) DEEMED ENROLLMENT RELATING TO CONVERTED REASONABLE COST REIMBURSEMENT CONTRACTS.—

''(A) IN GENERAL.—On the first day of the annual, coordinated election period under subsection (e)(3) for plan years beginning on or after January 1, 2017, an MA eligible individual described in clause (i) or (ii) of subparagraph (B) is deemed, unless the individual elects otherwise, to have elected to receive benefits under this title through an applicable MA plan (and shall be enrolled in such plan) beginning with such plan year, if—

''(i) the individual is enrolled in a reasonable cost reimbursement contract under section 1876(h) in the previous plan year;

''(ii) such reasonable cost reimbursement contract was extended or renewed for the last reasonable cost reimbursement contract year of the contract (as described in subclause (I) of section 1876(h)(5)(C)(iv)) pursuant to such section;

''(iii) the eligible organization that is offering such reasonable cost reimbursement contract provided the notice described in subclause (III) of such section that the contract was to be converted;

''(iv) the applicable MA plan—

''(I) is the plan that was converted from the reasonable cost reimbursement contract described in clause (iii);

''(II) is offered by the same entity (or an organization affiliated with such entity that has a common ownership interest of control) that entered into such contract; and

''(III) is offered in the service area where the individual resides;

''(v) in the case of reasonable cost reimbursement contracts that provide coverage under parts A and B (and, to the extent the Secretary determines it to be feasible, contracts that provide only part B coverage), the difference between the estimated individual costs (as determined applicable by the Secretary) for the applicable MA plan and such costs for the predecessor cost plan does not exceed a threshold established by the Secretary; and

''(vi) the applicable MA plan—

''(I) provides coverage for enrollees transitioning from the converted reasonable cost reimbursement contract to such plan to maintain current providers of services and suppliers and course of treatment at the time of enrollment for a period of at least 90 days after enrollment; and

''(II) during such period, pays such providers of services and suppliers for items and services furnished to the enrollee an amount that is not less than the amount of payment applicable for such items and services under the original Medicare fee-for-service program under parts A and B.

''(B) MA ELIGIBLE INDIVIDUALS DESCRIBED.—

''(i) WITHOUT PRESCRIPTION DRUG COVERAGE.—An MA eligible individual described in this clause, with respect to a plan year, is an MA eligible individual who is enrolled in a reasonable cost reimbursement contract under section 1876(h) in the previous plan year and who is not, for such previous plan year, enrolled in a prescription drug plan under part D, including coverage under section 1860D–22.

''(ii) WITH PRESCRIPTION DRUG COVERAGE.—An MA eligible individual described in this clause, with respect to a plan year, is an MA eligible individual who is enrolled in a reasonable cost reimbursement contract under section 1876(h) in the previous plan year and who, for such previous plan year, is enrolled in a prescription drug plan under part D—

''(I) through such contract; or

''(II) through a prescription drug plan, if the sponsor of such plan is the same entity (or an organization affiliated with such entity) that entered into such contract.

''(C) APPLICABLE MA PLAN DEFINED.—In this paragraph, the term 'applicable MA plan' means, in the case of an individual described in—

''(i) subparagraph (B)(i), an MA plan that is not an MA–PD plan; and

''(ii) subparagraph (B)(ii), an MA–PD plan.

''(D) IDENTIFICATION AND NOTIFICATION OF DEEMED INDIVIDUALS.—Not later than 45 days before the first day of the annual, coordinated election period under subsection (e)(3) for plan years beginning on or after January 1, 2017, the Secretary shall identify and notify the individuals who will be subject to deemed elections under subparagraph (A) on the first day of such period.''.

(2) BENEFICIARY OPTION TO DISCONTINUE OR CHANGE MA PLAN OR MA–PD PLAN AFTER DEEMED ENROLLMENT.—

(A) IN GENERAL.—Section 1851(e)(2) of the Social Security Act (42 U.S.C. 1395w–21(e)(4)) is amended by adding at the end the following:

''(F) SPECIAL PERIOD FOR CERTAIN DEEMED ELECTIONS.—

''(i) IN GENERAL.—At any time during the period beginning after the last day of the annual, coordinated election period under paragraph (3) in which an individual is deemed to have elected to enroll in an MA plan or MA–PD plan under subsection (c)(4) and ending on the last day of February of the first plan year for which the individual is enrolled in such plan, such individual may change the election under subsection (a)(1) (including changing the MA plan or MA–PD plan in which the individual is enrolled).

''(ii) LIMITATION OF ONE CHANGE.—An individual may exercise the right under clause (i) only once during the applicable period described in such clause. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).''.

(B) CONFORMING AMENDMENTS.—

(i) PLAN REQUIREMENT FOR OPEN ENROLLMENT.—Section 1851(e)(6)(A) of the Social Security Act (42 U.S.C. 1395w–21(e)(6)(A)) is amended by striking ''paragraph (1),'' and inserting ''paragraph (1), during the period described in paragraph (2)(F),''.

(ii) PART D.—Section 1860D–1(b)(1)(B) of such Act (42 U.S.C. 1395w–101(b)(1)(B)) is amended—

(I) in clause (ii), by adding ''and paragraph (4)'' after ''paragraph (3)(A)''; and

(II) in clause (iii) by striking ''and (E)'' and inserting ''(E), and (F)''.

(3) TREATMENT OF ESRD FOR DEEMED ENROLLMENT.—Section 1851(a)(3)(B) of the Social Security Act (42 U.S.C. 1395w–21(a)(3)(B)) is amended by adding at the end the following flush sentence: ''An individual who develops end-stage renal disease while enrolled in a reasonable cost reimbursement contract under section 1876(h) shall be treated as an MA eligible individual for purposes of applying the deemed enrollment under subsection (c)(4).''.

(c) INFORMATION REQUIREMENTS.—Section 1851(d)(2)(B) of the Social Security Act (42 U.S.C. 1395w–21(d)(2)(B)) is amended—

(1) in the heading, by striking ''NOTIFICATION TO NEWLY ELIGIBLE MEDICARE ADVANTAGE ELIGIBLE INDIVIDUALS'' and inserting the following: ''NOTIFICATIONS REQUIRED.—

''(i) NOTIFICATION TO NEWLY ELIGIBLE MEDICARE ADVANTAGE ELIGIBLE INDIVIDUALS.—''; and

(2) by adding at the end the following new clause:

''(ii) NOTIFICATION RELATED TO CERTAIN DEEMED ELECTIONS.—The Secretary shall require a Medicare Advantage organization that is offering a Medicare Advantage plan that has been converted from a reasonable cost reimbursement contract pursuant to section 1876(h)(5)(C)(iv) to mail, not later than 30 days prior to the first day of the annual, coordinated election period under subsection (e)(3) of a year, to any individual enrolled under such contract and identified by the Secretary under subsection (c)(4)(D) for such year—

''(I) a notification that such individual will, on such day, be deemed to have made an election with respect to such plan to receive benefits under this title through an MA plan or MA–PD plan (and shall be enrolled in such plan) for the next plan year under subsection (c)(4)(A), but that the individual may make a different election during the annual, coordinated election period for such year;

''(II) the information described in subparagraph (A);

''(III) a description of the differences between such MA plan or MA–PD plan and the reasonable cost reimbursement contract in which the individual was most recently enrolled with respect to benefits covered under such plans, including cost-sharing, premiums, drug coverage, and provider networks;

''(IV) information about the special period for elections under subsection (e)(2)(F); and

''(V) other information the Secretary may specify.''.

(d) TREATMENT OF TRANSITION PLAN FOR QUALITY RATING FOR PAYMENT PURPOSES.—Section 1853(o)(4) of the Social Security Act (42 U.S.C. 1395w–23(o)(4)) is amended by adding at the end the following new subparagraph:

''(C) SPECIAL RULE FOR FIRST 3 PLAN YEARS FOR PLANS THAT WERE CONVERTED FROM A REASONABLE COST REIMBURSEMENT CONTRACT.—For purposes of applying paragraph (1) and section 1854(b)(1)(C) for the first 3 plan years under this part in the case of an MA plan to which deemed enrollment applies under section 1851(c)(4)—

''(i) such plan shall not be treated as a new MA plan (as defined in paragraph (3)(A)(iii)(II)); and

''(ii) in determining the star rating of the plan under subparagraph (A), to the extent that Medicare Advantage data for such plan is not available for a measure used to determine such star rating, the Secretary shall use data from the period in which such plan was a reasonable cost reimbursement contract.''.

SEC. 210. EXTENSION OF HOME HEALTH RURAL ADD-ON.

Section 421(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2283; 42 U.S.C. 1395fff note), as amended by section 5201(b) of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 46) and by section 3131(c) of the Patient Protection and Affordable Care Act (Public Law 111–148; 124 Stat. 428), is amended by striking ''January 1, 2016'' and inserting ''January 1, 2018'' each place it appears.

Subtitle B—Other Health Extenders

SEC. 211. PERMANENT EXTENSION OF THE QUALIFYING INDIVIDUAL (QI) PROGRAM.

(a) PERMANENT EXTENSION.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended by striking ''(but only for premiums payable

with respect to months during the period beginning with January 1998, and ending with March 2015)''.

(b) ALLOCATIONS.—Section 1933(g) of the Social Security Act (42 U.S.C. 1396u–3(g)) is amended—

(1) in paragraph (2)—

(A) by striking subparagraphs (A) through (H);

(B) in subparagraph (V), by striking ''and'' at the end;

(C) in subparagraph (W), by striking the period at the end and inserting a semicolon;

(D) by redesignating subparagraphs (I) through (W) as subparagraphs (A) through (O), respectively; and

(E) by adding at the end the following new subparagraphs:

''(P) for the period that begins on April 1, 2015, and ends on December 31, 2015, the total allocation amount is $535,000,000; and

''(Q) for 2016 and, subject to paragraph (4), for each subsequent year, the total allocation amount is $980,000,000.'';

(2) in paragraph (3), by striking ''(P), (R), (T), or (V)'' and inserting ''or (P)''; and

(3) by adding at the end the following new paragraph:

''(4) ADJUSTMENT TO ALLOCATIONS.—The Secretary may increase the allocation amount under paragraph (2)(Q) for a year (beginning with 2017) up to an amount that does not exceed the product of the following:

''(A) MAXIMUM ALLOCATION AMOUNT FOR PREVIOUS YEAR.—In the case of 2017, the allocation amount for 2016, or in the case of a subsequent year, the maximum allocation amount allowed under this paragraph for the previous year.

''(B) INCREASE IN PART B PREMIUM.—The monthly premium rate determined under section 1839 for the year divided by the monthly premium rate determined under such section for the previous year.

''(C) INCREASE IN PART B ENROLLMENT.—The average number of individuals (as estimated by the Chief Actuary of the Centers for Medicare & Medicaid Services in September of the previous year) to be enrolled under part B of title XVIII for months in the year divided by the average number of such individuals (as so estimated) under this subparagraph with respect to enrollments in months in the previous year.''.

SEC. 212. PERMANENT EXTENSION OF TRANSITIONAL MEDICAL ASSISTANCE (TMA).

(a) IN GENERAL.—Section 1925 of the Social Security Act (42 U.S.C. 1396r–6) is amended—

(1) by striking subsection (f); and

(2) by redesignating subsection (g) as subsection (f).

(b) CONFORMING AMENDMENT.—Section 1902(e)(1) of the Social Security Act (42 U.S.C. 1396a(e)(1)) is amended to read as follows:

''(1) Beginning April 1, 1990, for provisions relating to the extension of eligibility for medical assistance for certain families who have received aid pursuant to a State plan approved under part A of title IV and have earned income, see section 1925.''.

SEC. 213. EXTENSION OF SPECIAL DIABETES PROGRAM FOR TYPE I DIABETES AND FOR INDIANS.

(a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES.—Section 330B(b)(2)(C) of the Public Health Service Act (42 U.S.C. 254c–2(b)(2)(C)) is amended by striking ''2015'' and inserting ''2017''.

(b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—Section 330C(c)(2)(C) of the Public Health Service Act (42 U.S.C. 254c–3(c)(2)(C)) is amended by striking ''2015'' and inserting ''2017''.

SEC. 214. EXTENSION OF ABSTINENCE EDUCATION.

(a) IN GENERAL.—Section 510 of the Social Security Act (42 U.S.C. 710) is amended—

(1) in subsection (a), striking ''2015'' and inserting ''2017''; and

(2) in subsection (d), by inserting ''and an additional $75,000,000 for each of fiscal years 2016 and 2017'' after ''2015''.

(b) BUDGET SCORING.—Notwithstanding section 257(b)(2) of the Balanced Budget and Emergency Deficit Control Act of 1985, the baseline shall be calculated assuming that no grant shall be made under section 510 of the Social Security Act (42 U.S.C. 710) after fiscal year 2017.

(c) REALLOCATION OF UNUSED FUNDING.—The remaining unobligated balances of the amount appropriated for fiscal years 2016 and 2017 by section 510(d) of the Social Security Act (42 U.S.C. 710(d)) for which no application has been received by the Funding Opportunity Announcement deadline, shall be made available to States that require the implementation of each element described in subparagraphs (A) through (H) of the definition of abstinence education in section 510(b)(2). The remaining unobligated balances shall be reallocated to such States that submit a valid application consistent with the original formula for this funding.

SEC. 215. EXTENSION OF PERSONAL RESPONSIBILITY EDUCATION PROGRAM (PREP).

Section 513 of the Social Security Act (42 U.S.C. 713) is amended—

(1) in paragraphs (1)(A) and (4)(A) of subsection (a), by striking ''2015'' and inserting ''2017'' each place it appears;

(2) in subsection (a)(4)(B)(i), by striking '', 2013, 2014, and 2015'' and inserting ''through 2017''; and

(3) in subsection (f), by striking ''2015'' and inserting ''2017''.

SEC. 216. EXTENSION OF FUNDING FOR FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

Section 501(c)(1)(A) of the Social Security Act (42 U.S.C. 701(c)(1)(A)) is amended—

(1) by striking clause (vi); and

(2) by adding after clause (v) the following new clause:

''(vi) $5,000,000 for each of fiscal years 2015 through 2017.''.

SEC. 217. EXTENSION OF HEALTH WORKFORCE DEMONSTRATION PROJECT FOR LOW-INCOME INDIVIDUALS.

Section 2008(c)(1) of the Social Security Act (42 U.S.C. 1397g(c)(1)) is amended by striking ''2015'' and inserting ''2017''.

SEC. 218. EXTENSION OF MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

Section 511(j)(1) of the Social Security Act (42 U.S.C. 711(j)) is amended—

(1) by striking ''and'' at the end of subparagraph (E);

(2) in subparagraph (F)—

(A) by striking ''for the period beginning on October 1, 2014, and ending on March 31, 2015'' and inserting ''for fiscal year 2015'';

(B) by striking ''an amount equal to the amount provided in subparagraph (E)'' and inserting ''$400,000,000''; and

(C) by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new subparagraphs:

''(G) for fiscal year 2016, $400,000,000; and

''(H) for fiscal year 2017, $400,000,000.''.

SEC. 219. TENNESSEE DSH ALLOTMENT FOR FISCAL YEARS 2015 THROUGH 2025.

Section 1923(f)(6)(A) of the Social Security Act (42 U.S.C. 1396r–4(f)(6)(A)) is amended by adding at the end the following:

''(vi) ALLOTMENT FOR FISCAL YEARS 2015 THROUGH 2025.—Notwithstanding any other provision of this subsection, any other provision of law, or the terms of the TennCare Demonstration Project in effect for the State, the DSH allotment for Tennessee for fiscal year 2015, and for each fiscal year thereafter through fiscal year 2025, shall be $53,100,000 for each such fiscal year.''.

SEC. 220. DELAY IN EFFECTIVE DATE FOR MEDICAID AMENDMENTS RELATING TO BENEFICIARY LIABILITY SETTLEMENTS.

Section 202(c) of the Bipartisan Budget Act of 2013 (division A of Public Law 113–67; 42 U.S.C. 1396a note), as amended by section 211 of the Protecting Access to Medicare Act of 2014 (Public Law 113–93; 128 Stat. 1047) is amended by striking ''October 1, 2016'' and inserting ''October 1, 2017''.

SEC. 221. EXTENSION OF FUNDING FOR COMMUNITY HEALTH CENTERS, THE NATIONAL HEALTH SERVICE CORPS, AND TEACHING HEALTH CENTERS.

(a) FUNDING FOR COMMUNITY HEALTH CENTERS AND THE NATIONAL HEALTH SERVICE CORPS.—

(1) COMMUNITY HEALTH CENTERS.—Section 10503(b)(1)(E) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2(b)(1)(E)) is amended by striking ''for fiscal year 2015'' and inserting ''for each of fiscal years 2015 through 2017''.

(2) NATIONAL HEALTH SERVICE CORPS.—Section 10503(b)(2)(E) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2(b)(2)(E)) is amended by striking ''for fiscal year 2015'' and inserting ''for each of fiscal years 2015 through 2017''.

(b) EXTENSION OF TEACHING HEALTH CENTERS PROGRAM.—Section 340H(g) of the Public Health Service Act (42 U.S.C. 256h(g)) is amended by inserting ''and $60,000,000 for each of fiscal years 2016 and 2017'' before the period at the end.

(c) APPLICATION.—Amounts appropriated pursuant to this section for fiscal year 2016 and fiscal year 2017 are subject to the requirements contained in Public Law 113–235 for funds for programs authorized under sections 330 through 340 of the Public Health Service Act (42 U.S.C. 254b–256).

TITLE III—CHIP

SEC. 301. 2-YEAR EXTENSION OF THE CHILDREN'S HEALTH INSURANCE PROGRAM.

(a) FUNDING.—Section 2104(a) of the Social Security Act (42 U.S.C. 1397dd(a)) is amended—

(1) in paragraph (17), by striking ''and'' at the end;

(2) in paragraph (18)(B), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new paragraphs:

''(19) for fiscal year 2016, $19,300,000,000; and

''(20) for fiscal year 2017, for purposes of making 2 semi-annual allotments—

''(A) $2,850,000,000 for the period beginning on October 1, 2016, and ending on March 31, 2017; and

''(B) $2,850,000,000 for the period beginning on April 1, 2017, and ending on September 30, 2017.''.

(b) ALLOTMENTS.—

(1) IN GENERAL.—Section 2104(m) of the Social Security Act (42 U.S.C. 1397dd(m)) is amended—

(A) in the subsection heading, by striking ''THROUGH 2015'' and inserting ''AND THEREAFTER'';

(B) in paragraph (2)—

(i) in the paragraph heading, by striking ''2014'' and inserting ''2016''; and

(ii) by striking subparagraph (B) and inserting the following new subparagraph:

''(B) FISCAL YEAR 2013 AND EACH SUCCEEDING FISCAL YEAR.—Subject to paragraphs (5) and (7), from the amount made available under paragraphs (16) through (19) of subsection (a) for fiscal year 2013 and each succeeding fiscal year, respectively, the Secretary shall compute a State allotment for each State (including the District of Columbia and each

commonwealth and territory) for each such fiscal year as follows:

''(i) REBASING IN FISCAL YEAR 2013 AND EACH SUCCEEDING ODD-NUMBERED FISCAL YEAR.—For fiscal year 2013 and each succeeding odd-numbered fiscal year (other than fiscal years 2015 and 2017), the allotment of the State is equal to the Federal payments to the State that are attributable to (and countable toward) the total amount of allotments available under this section to the State in the preceding fiscal year (including payments made to the State under subsection (n) for such preceding fiscal year as well as amounts redistributed to the State in such preceding fiscal year), multiplied by the allotment increase factor under paragraph (6) for such odd-numbered fiscal year.

''(ii) GROWTH FACTOR UPDATE FOR FISCAL YEAR 2014 AND EACH SUCCEEDING EVEN-NUMBERED FISCAL YEAR.—Except as provided in clauses (iii) and (iv), for fiscal year 2014 and each succeeding even-numbered fiscal year, the allotment of the State is equal to the sum of—

''(I) the amount of the State allotment under clause (i) for the preceding fiscal year; and

''(II) the amount of any payments made to the State under subsection (n) for such preceding fiscal year,

multiplied by the allotment increase factor under paragraph (6) for such even-numbered fiscal year.

''(iii) SPECIAL RULE FOR 2016.—For fiscal year 2016, the allotment of the State is equal to the Federal payments to the State that are attributable to (and countable toward) the total amount of allotments available under this section to the State in the preceding fiscal year (including payments made to the State under subsection (n) for such preceding fiscal year as well as amounts redistributed to the State in such preceding fiscal year), but determined as if the last two sentences of section 2105(b) were in effect in such preceding fiscal year and then multiplying the result by the allotment increase factor under paragraph (6) for fiscal year 2016.

''(iv) REDUCTION IN 2018.—For fiscal year 2018, with respect to the allotment of the State for fiscal year 2017, any amounts of such allotment that remain available for expenditure by the State in fiscal year 2018 shall be reduced by one-third.'';

(C) in paragraph (4), by inserting ''or 2017'' after ''2015'';

(D) in paragraph (6)—

(i) in subparagraph (A), by striking ''2015'' and inserting ''2017''; and

(ii) in the second sentence, by striking ''or fiscal year 2014'' and inserting ''fiscal year 2014, or fiscal year 2016'';

(E) in paragraph (8)—

(i) in the paragraph heading, by striking ''FISCAL YEAR 2015'' and inserting ''FISCAL YEARS 2015 AND 2017''; and

(ii) by inserting ''or fiscal year 2017'' after ''2015'';

(F) by redesignating paragraphs (4) through (8) as paragraphs (5) through (9), respectively; and

(G) by inserting after paragraph (3) the following new paragraph:

''(4) FOR FISCAL YEAR 2017.—

''(A) FIRST HALF.—Subject to paragraphs (5) and (7), from the amount made available under subparagraph (A) of paragraph (20) of subsection (a) for the semi-annual period described in such paragraph, increased by the amount of the appropriation for such period under section 301(b)(3) of the Medicare Access and CHIP Reauthorization Act of 2015, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the first half ratio (described in subparagraph (D)) of the amount described in subparagraph (C).

''(B) SECOND HALF.—Subject to paragraphs (5) and (7), from the amount made available under subparagraph (B) of paragraph (20) of subsection (a) for the semi-annual period described in such paragraph, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the amount made available under such subparagraph, multiplied by the ratio of—

''(i) the amount of the allotment to such State under subparagraph (A); to

''(ii) the total of the amount of all of the allotments made available under such subparagraph.

''(C) FULL YEAR AMOUNT BASED ON REBASED AMOUNT.—The amount described in this subparagraph for a State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2016 (including payments made to the State under subsection (n) for fiscal year 2016 as well as amounts redistributed to the State in fiscal year 2016), multiplied by the allotment increase factor under paragraph (6) for fiscal year 2017.

''(D) FIRST HALF RATIO.—The first half ratio described in this subparagraph is the ratio of—

''(i) the sum of—

''(I) the amount made available under subsection (a)(20)(A); and

''(II) the amount of the appropriation for such period under section 301(b)(3) of the Medicare Access and CHIP Reauthorization Act of 2015; to

''(ii) the sum of the—

''(I) amount described in clause (i); and

''(II) the amount made available under subsection (a)(20)(B).''.

(2) CONFORMING AMENDMENTS.——

(A) Section 2104(c)(1) of the Social Security Act (42 U.S.C. 1397dd(c)(1)) is amended by striking ''(m)(4)'' and inserting ''(m)(5)''.

(B) Section 2104(m) of such Act (42 U.S.C. 1397dd(m)), as amended by paragraph (1), is further amended—

(ii) in paragraph (1)—

(I) by striking ''paragraph (4)'' each place it appears in subparagraphs (A) and (B) and inserting ''paragraph (5)''; and

(II) by striking ''the allotment increase factor determined under paragraph (5)'' each place it appears and inserting ''the allotment increase factor determined under paragraph (6)'';

(iii) in paragraph (2)(A), by striking ''the allotment increase factor under paragraph (5)'' and inserting ''the allotment increase factor under paragraph (6)'';

(iv) in paragraph (3)—

(I) by striking ''paragraphs (4) and (6)'' and inserting ''paragraphs (5) and (7)'' each place it appears; and

(II) by striking ''the allotment increase factor under paragraph (5)'' and inserting ''the allotment increase factor under paragraph (6)'';

(v) in paragraph (5) (as redesignated by paragraph (1)(F)), by striking ''paragraph (1), (2), or (3)'' and inserting ''paragraph (1), (2), (3), or (4)'';

(vi) in paragraph (7) (as redesignated by paragraph (1)(F)), by striking ''subject to paragraph (4)'' and inserting ''subject to paragraph (5)''; and

(vii) in paragraph (9), (as redesignated by paragraph (1)(F)), by striking ''paragraph (3)'' and inserting ''paragraph (3) or (4)''.

(C) Section 2104(n)(3)(B)(ii) of such Act (42 U.S.C. 1397dd(n)(3)(B)(ii)) is amended by striking ''subsection (m)(5)(B)'' and inserting ''subsection (m)(6)(B)''.

(D) Section 2111(b)(2)(B)(i) of such Act (42 U.S.C. 1397kk(b)(2)(B)(i)) is amended by striking ''section 2104(m)(4)'' and inserting ''section 2104(m)(5)''.

(3) ONE-TIME APPROPRIATION FOR FISCAL YEAR 2017.—There is appropriated to the Secretary of Health and Human Services, out of any money in the Treasury not otherwise appropriated, $14,700,000,000 to accompany the allotment made for the period beginning on October 1, 2016, and ending on March 31, 2017, under paragraph (20)(A) of section 2104(a) of the Social Security Act (42 U.S.C. 1397dd(a)) (as added by subsection (a)(1)), to remain available until expended. Such amount shall be used to provide allotments to States under paragraph (4) of section 2104(m) of such Act (42 U.S.C. 1397dd(m)) (as amended by paragraph (1)(G)) for the first 6 months of fiscal year 2017 in the same manner as allotments are provided under subsection (a)(20)(A) of such section 2104 and subject to the same terms and conditions as apply to the allotments provided from such subsection (a)(20)(A).

(c) EXTENSION OF QUALIFYING STATES OPTION.—Section 2105(g)(4) of the Social Security Act (42 U.S.C. 1397ee(g)(4)) is amended—

(1) in the paragraph heading, by striking ''2015'' and inserting ''2017''; and

(2) in subparagraph (A), by striking ''2015'' and inserting ''2017''.

(d) EXTENSION OF THE CHILD ENROLLMENT CONTINGENCY FUND.—

(1) IN GENERAL.—Section 2104(n) of the Social Security Act (42 U.S.C. 1397dd(n)) is amended—

(A) in paragraph (2)—

(i) in subparagraph (A)(ii)—

(I) by striking ''2010 through 2014'' and inserting ''2010, 2011, 2012, 2013, 2014, and 2016''; and

(II) by inserting ''and fiscal year 2017'' after ''2015''; and

(ii) in subparagraph (B)—

(I) by striking ''2010 through 2014'' and inserting ''2010, 2011, 2012, 2013, 2014, and 2016''; and

(II) by inserting ''and fiscal year 2017'' after ''2015''; and

(B) in paragraph (3)(A), in the matter preceding clause (i), by striking ''fiscal year 2009, fiscal year 2010, fiscal year 2011, fiscal year 2012, fiscal year 2013, fiscal year 2014, or a semi-annual allotment period for fiscal year 2015'' and inserting ''any of fiscal years 2009 through 2014, fiscal year 2016, or a semi-annual allotment period for fiscal year 2015 or 2017''.

SEC. 302. EXTENSION OF EXPRESS LANE ELIGIBILITY.

Section 1902(e)(13)(I) of the Social Security Act (42 U.S.C. 1396a(e)(13)(I)) is amended by striking ''2015'' and inserting ''2017''.

SEC. 303. EXTENSION OF OUTREACH AND ENROLLMENT PROGRAM.

Section 2113 of the Social Security Act (42 U.S.C. 1397mm) is amended—

(1) in subsection (a)(1), by striking ''2015'' and inserting ''2017''; and

(2) in subsection (g), by inserting ''and $40,000,000 for the period of fiscal years 2016 and 2017'' after ''2015''.

SEC. 304. EXTENSION OF CERTAIN PROGRAMS AND DEMONSTRATION PROJECTS.

(a) CHILDHOOD OBESITY DEMONSTRATION PROJECT.—Section 1139A(e)(8) of the Social Security Act (42 U.S.C. 1320b–9a(e)(8)) is amended by inserting '', and $10,000,000 for the period of fiscal years 2016 and 2017'' after ''2014''.

(b) PEDIATRIC QUALITY MEASURES PROGRAM.—Section 1139A(i) of the Social Security Act (42 U.S.C. 1320b–9a(i)) is amended in the first sentence by inserting before the period at the end the following: '', and there is

appropriated for the period of fiscal years 2016 and 2017, $20,000,000 for the purpose of carrying out this section (other than subsections (e), (f), and (g))''.

SEC. 305. REPORT OF INSPECTOR GENERAL OF HHS ON USE OF EXPRESS LANE OPTION UNDER MEDICAID AND CHIP.

Not later than 18 months after the date of the enactment of this Act, the Inspector General of the Department of Health and Human Services shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report that—

(1) provides data on the number of individuals enrolled in the Medicaid program under title XIX of the Social Security Act (referred to in this section as ''Medicaid'') and the Children's Health Insurance Program under title XXI of such Act (referred to in this section as ''CHIP'') through the use of the Express Lane option under section 1902(e)(13) of the Social Security Act (42 U.S.C. 1396a(e)(13));

(2) assesses the extent to which individuals so enrolled meet the eligibility requirements under Medicaid or CHIP (as applicable); and

(3) provides data on Federal and State expenditures under Medicaid and CHIP for individuals so enrolled and disaggregates such data between expenditures made for individuals who meet the eligibility requirements under Medicaid or CHIP (as applicable) and expenditures made for individuals who do not meet such requirements.

TITLE IV—OFFSETS

Subtitle A—Medicare Beneficiary Reforms

SEC. 401. LIMITATION ON CERTAIN MEDIGAP POLICIES FOR NEWLY ELIGIBLE MEDICARE BENEFICIARIES.

Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

''(z) LIMITATION ON CERTAIN MEDIGAP POLICIES FOR NEWLY ELIGIBLE MEDICARE BENEFICIARIES.—

''(1) IN GENERAL.—Notwithstanding any other provision of this section, on or after January 1, 2020, a medicare supplemental policy that provides coverage of the part B deductible, including any such policy (or rider to such a policy) issued under a waiver granted under subsection (p)(6), may not be sold or issued to a newly eligible Medicare beneficiary.

''(2) NEWLY ELIGIBLE MEDICARE BENEFICIARY DEFINED.—In this subsection, the term 'newly eligible Medicare beneficiary' means an individual who is neither of the following:

''(A) An individual who has attained age 65 before January 1, 2020.

''(B) An individual who was entitled to benefits under part A pursuant to section 226(b) or 226A, or deemed to be eligible for benefits under section 226(a), before January 1, 2020.

''(3) TREATMENT OF WAIVERED STATES.—In the case of a State described in subsection (p)(6), nothing in this section shall be construed as preventing the State from modifying its alternative simplification program under such subsection so as to eliminate the coverage of the part B deductible for any medical supplemental policy sold or issued under such program to a newly eligible Medicare beneficiary on or after January 1, 2020.

''(4) TREATMENT OF REFERENCES TO CERTAIN POLICIES.—In the case of a newly eligible Medicare beneficiary, except as the Secretary may otherwise provide, any reference in this section to a medicare supplemental policy which has a benefit package classified as 'C' or 'F' shall be deemed, as of January 1, 2020, to be a reference to a medicare supplemental policy which has a benefit package classified as 'D' or 'G', respectively.

''(5) ENFORCEMENT.—The penalties described in clause (ii) of subsection (d)(3)(A) shall apply with respect to a violation of paragraph (1) in the same manner as it applies to a violation of clause (i) of such subsection.''.

SEC. 402. INCOME-RELATED PREMIUM ADJUSTMENT FOR PARTS B AND D.

(a) IN GENERAL.—Section 1839(i)(3)(C)(i) of the Social Security Act (42 U.S.C. 1395r(i)(3)(C)(i)) is amended—

(1) by inserting after ''IN GENERAL.—'' the following:

''(I) Subject to paragraphs (5) and (6), for years before 2018:''; and

(2) by adding at the end the following:

''(II) Subject to paragraph (5), for years beginning with 2018:

''If the modified adjusted gross income is:	**The applicable percentage is:**
More than $85,000 but not more than $107,000	35 percent
More than $107,000 but not more than $133,500	50 percent
More than $133,500 but not more than $160,000	65 percent
More than $160,000	80 percent.''.

(b) CONFORMING AMENDMENTS.—Section 1839(i) of the Social Security Act (42 U.S.C. 1395r(i)) is amended—

(1) in paragraph (2)(A), by inserting ''(or, beginning with 2018, $85,000)'' after ''$80,000'';

(2) in paragraph (3)(A)(i), by inserting ''applicable'' before ''table'';

(3) in paragraph (5)(A)—

(A) in the matter before clause (i), by inserting ''(other than 2018 and 2019)'' after ''2007''; and

(B) in clause (ii), by inserting ''(or, in the case of a calendar year beginning with 2020, August 2018)'' after ''August 2006''; and

(4) in paragraph (6), in the matter before subparagraph (A), by striking ''2019'' and inserting ''2017''.

Subtitle B—Other Offsets

SEC. 411. MEDICARE PAYMENT UPDATES FOR POST-ACUTE PROVIDERS.

(a) SNFs.—Section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e))—

(1) in paragraph (5)(B)—

(A) in clause (i), by striking ''clause (ii)'' and inserting ''clauses (ii) and (iii)'';

(B) in clause (ii), by inserting ''subject to clause (iii),'' after ''each subsequent fiscal year,''; and

(C) by adding at the end the following new clause:

''(iii) SPECIAL RULE FOR FISCAL YEAR 2018.—For fiscal year 2018 (or other similar annual period specified in clause (i)), the skilled nursing facility market basket percentage, after application of clause (ii), is equal to 1 percent.''; and

(2) in paragraph (6)(A), by striking ''paragraph (5)(B)(ii)'' and inserting ''clauses (ii) and (iii) of paragraph (5)(B)'' each place it appears.

(b) IRFs.—Section 1886(j) of the Social Security Act (42 U.S.C. 1395ww(j)) is amended—

(1) in paragraph (3)(C)—

(A) in clause (i), by striking ''clause (ii)'' and inserting ''clauses (ii) and (iii)'';

(B) in clause (ii), by striking ''After'' and inserting ''Subject to clause (iii), after''; and

(C) by adding at the end the following new clause:

''(iii) SPECIAL RULE FOR FISCAL YEAR 2018.—The increase factor to be applied under this subparagraph for fiscal year 2018, after the application of clause (ii), shall be 1 percent.''; and

(2) in paragraph (7)(A)(i), by striking ''paragraph (3)(D)'' and inserting ''subparagraphs (C)(iii) and (D) of paragraph (3)''.

(c) HHAs.—Section 1895(b)(3)(B) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—

(1) in clause (iii), by adding at the end the following: ''Notwithstanding the previous sentence, the home health market basket percentage increase for 2018 shall be 1 percent.''; and

(2) in clause (vi)(I), by inserting ''(except 2018)'' after ''each subsequent year''.

(d) HOSPICE.—Section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) is amended—

(1) in paragraph (1)(C)—

(A) in clause (ii)(VII), by striking ''clause (iv),,'' and inserting ''clauses (iv) and (vi),'';

(B) in clause (iii), by striking ''clause (iv),'' and inserting ''clauses (iv) and (vi),'';

(C) in clause (iv), by striking ''After determining'' and inserting ''Subject to clause (vi), after determining''; and

(D) by adding at the end the following new clause:

''(vi) For fiscal year 2018, the market basket percentage increase under clause (ii)(VII) or (iii), as applicable, after application of clause (iv), shall be 1 percent.''; and

(2) in paragraph (5)(A)(i), by striking ''paragraph (1)(C)(iv)'' and inserting ''clauses (iv) and (vi) of paragraph (1)(C)''.

(e) LTCHs.—Section 1886(m)(3) of the Social Security Act (42 U.S.C. 1395ww(m)(3)) is amended—

(1) in subparagraph (A), in the matter preceding clause (i), by striking ''In implementing'' and inserting ''Subject to subparagraph (C), in implementing''; and

(2) by adding at the end the following new subparagraph:

''(C) ADDITIONAL SPECIAL RULE.—For fiscal year 2018, the annual update under subparagraph (A) for the fiscal year, after application of clauses (i) and (ii) of subparagraph (A), shall be 1 percent.''.

SEC. 412. DELAY OF REDUCTION TO MEDICAID DSH ALLOTMENTS.

Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(1) in paragraph (7)(A)—

(A) in clause (i), by striking ''2017 through 2024'' and inserting ''2018 through 2025'';

(B) by striking clause (ii) and inserting the following new clause:

''(ii) AGGREGATE REDUCTIONS.—The aggregate reductions in DSH allotments for all States under clause (i)(I) shall be equal to—

''(I) $2,000,000,000 for fiscal year 2018;

''(II) $3,000,000,000 for fiscal year 2019;

''(III) $4,000,000,000 for fiscal year 2020;

''(IV) $5,000,000,000 for fiscal year 2021;

''(V) $6,000,000,000 for fiscal year 2022;

''(VI) $7,000,000,000 for fiscal year 2023;

''(VII) $8,000,000,000 for fiscal year 2024; and

''(VIII) $8,000,000,000 for fiscal year 2025.''; and

(C) by adding at the end the following new clause:

''(v) DISTRIBUTION OF AGGREGATE REDUCTIONS.—The Secretary shall distribute the aggregate reductions under clause (ii) among States in accordance with subparagraph (B).''; and

(2) in paragraph (8), by striking ''2024'' and inserting ''2025''.

SEC. 413. LEVY ON DELINQUENT PROVIDERS.

(a) IN GENERAL.—Paragraph (3) of section 6331(h) of the Internal Revenue Code of 1986 is amended by striking ''30 percent'' and inserting ''100 percent''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to payments made after 180 days after the date of the enactment of this Act.

SEC. 414. ADJUSTMENTS TO INPATIENT HOSPITAL PAYMENT RATES.

Section 7(b) of the TMA, Abstinence Education, and QI Programs Extension Act of 2007 (Public Law 110–90), as amended by section 631(b) of the American Taxpayer Relief Act of 2012 (Public Law 112–240), is amended—

(1) in paragraph (1)—

(A) in the matter preceding subparagraph (A), by striking '', 2009, or 2010'' and inserting ''or 2009''; and

(B) in subparagraph (B)—

(i) in clause (i), by striking ''and'' at the end;

(ii) in clause (ii), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following new clause:

''(iii) make an additional adjustment to the standardized amounts under such section 1886(d) of an increase of 0.5 percentage points for discharges occurring during each of fiscal years 2018 through 2023 and not make the adjustment (estimated to be an increase of 3.2 percent) that would otherwise apply for discharges occurring during fiscal year 2018 by reason of the completion of the adjustments required under clause (ii).'';

(2) in paragraph (3)—

(A) by striking ''shall be construed'' and all that follows through ''providing authority'' and inserting ''shall be construed as providing authority''; and

(B) by inserting ''and each succeeding fiscal year through fiscal year 2023'' after ''2017'';

(3) by redesignating paragraphs (3) and (4) as paragraphs (4) and (5), respectively; and

(4) by inserting after paragraph (2) the following new paragraph:

''(3) PROHIBITION.—The Secretary shall not make an additional prospective adjustment (estimated to be a decrease of 0.55 percent) to the standardized amounts under such section 1886(d) to offset the amount of the increase in aggregate payments related to documentation and coding changes for discharges occurring during fiscal year 2010.''.

TITLE V—MISCELLANEOUS

Subtitle A—Protecting the Integrity of Medicare

SEC. 501. PROHIBITION OF INCLUSION OF SOCIAL SECURITY ACCOUNT NUMBERS ON MEDICARE CARDS.

(a) IN GENERAL.—Section 205(c)(2)(C) of the Social Security Act (42 U.S.C. 405(c)(2)(C)) is amended—

(1) by moving clause (x), as added by section 1414(a)(2) of the Patient Protection and Affordable Care Act, 6 ems to the left;

(2) by redesignating clause (x), as added by section 2(a)(1) of the Social Security Number Protection Act of 2010, and clause (xi) as clauses (xi) and (xii), respectively; and

(3) by adding at the end the following new clause:

''(xiii) The Secretary of Health and Human Services, in consultation with the Commissioner of Social Security, shall establish cost-effective procedures to ensure that a Social Security account number (or derivative thereof) is not displayed, coded, or embedded on the Medicare card issued to an individual who is entitled to benefits under part A of title XVIII or enrolled under part B of title XVIII and that any other identifier displayed on such card is not identifiable as a Social Security account number (or derivative thereof).''.

(b) IMPLEMENTATION.—In implementing clause (xiii) of section 205(c)(2)(C) of the Social Security Act (42 U.S.C. 405(c)(2)(C)), as added by subsection (a)(3), the Secretary of Health and Human Services shall do the following:

(1) IN GENERAL.—Establish a cost-effective process that involves the least amount of disruption to, as well as necessary assistance for, Medicare beneficiaries and health care providers, such as a process that provides such beneficiaries with access to assistance through a toll-free telephone number and provides outreach to providers.

(2) CONSIDERATION OF MEDICARE BENEFICIARY IDENTIFIED.—Consider implementing a process, similar to the process involving Railroad Retirement Board beneficiaries, under which a Medicare beneficiary identifier which is not a Social Security account number (or derivative thereof) is used external to the Department of Health and Human Services and is convertible over to a Social Security account number (or derivative thereof) for use internal to such Department and the Social Security Administration.

(c) FUNDING FOR IMPLEMENTATION.—For purposes of implementing the provisions of and the amendments made by this section, the Secretary of Health and Human Services shall provide for the following transfers from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportions as the Secretary determines appropriate:

(1) To the Centers for Medicare & Medicaid Program Management Account, transfers of the following amounts:

(A) For fiscal year 2015, $65,000,000, to be made available through fiscal year 2018.

(B) For each of fiscal years 2016 and 2017, $53,000,000, to be made available through fiscal year 2018.

(C) For fiscal year 2018, $48,000,000, to be made available until expended.

(2) To the Social Security Administration Limitation on Administration Account, transfers of the following amounts:

(A) For fiscal year 2015, $27,000,000, to be made available through fiscal year 2018.

(B) For each of fiscal years 2016 and 2017, $22,000,000, to be made available through fiscal year 2018.

(C) For fiscal year 2018, $27,000,000, to be made available until expended.

(3) To the Railroad Retirement Board Limitation on Administration Account, the following amount:

(A) For fiscal year 2015, $3,000,000, to be made available until expended.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Clause (xiii) of section 205(c)(2)(C) of the Social Security Act (42 U.S.C. 405(c)(2)(C)), as added by subsection (a)(3), shall apply with respect to Medicare cards issued on and after an effective date specified by the Secretary of Health and Human Services, but in no case shall such effective date be later than the date that is four years after the date of the enactment of this Act.

(2) REISSUANCE.—The Secretary shall provide for the reissuance of Medicare cards that comply with the requirements of such clause not later than four years after the effective date specified by the Secretary under paragraph (1).

SEC. 502. PREVENTING WRONGFUL MEDICARE PAYMENTS FOR ITEMS AND SERVICES FURNISHED TO INCARCERATED INDIVIDUALS, INDIVIDUALS NOT LAWFULLY PRESENT, AND DECEASED INDIVIDUALS.

(a) REQUIREMENT FOR THE SECRETARY TO ESTABLISH POLICIES AND CLAIMS EDITS RELATING TO INCARCERATED INDIVIDUALS, INDIVIDUALS NOT LAWFULLY PRESENT, AND DECEASED INDIVIDUALS.—Section 1874 of the Social Security Act (42 U.S.C. 1395kk) is amended by adding at the end the following new subsection:

''(f) REQUIREMENT FOR THE SECRETARY TO ESTABLISH POLICIES AND CLAIMS EDITS RELATING TO INCARCERATED INDIVIDUALS, INDIVIDUALS NOT LAWFULLY PRESENT, AND DECEASED INDIVIDUALS.—The Secretary shall establish and maintain procedures, including procedures for using claims processing edits, updating eligibility information to improve provider accessibility, and conducting recoupment activities such as through recovery audit contractors, in order to ensure that payment is not made under this title for items and services furnished to an individual who is one of the following:

''(1) An individual who is incarcerated.

''(2) An individual who is not lawfully present in the United States and who is not eligible for coverage under this title.

''(3) A deceased individual.''.

(b) REPORT.—Not later than 18 months after the date of the enactment of this section, and periodically thereafter as determined necessary by the Office of Inspector General of the Department of Health and Human Services, such Office shall submit to Congress a report on the activities described in subsection (f) of section 1874 of the Social Security Act (42 U.S.C. 1395kk), as added by subsection (a), that have been conducted since such date of enactment.

SEC. 503. CONSIDERATION OF MEASURES REGARDING MEDICARE BENEFICIARY SMART CARDS.

To the extent the Secretary of Health and Human Services determines that it is cost effective and technologically viable to use electronic Medicare beneficiary and provider cards (such as cards that use smart card technology, including an embedded and secure integrated circuit chip), as presented in the Government Accountability Office report required by the conference report accompanying the Consolidated Appropriations Act, 2014 (Public Law 113–76), the Secretary shall consider such measures as determined appropriate by the Secretary to implement such use of such cards for beneficiary and provider use under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). In the case that the Secretary considers measures under the preceding sentence, the Secretary shall submit to the Committees on Ways and Means and Energy and Commerce of the House of Representatives, and to the Committee on Finance of the Senate, a report outlining the considerations undertaken by the Secretary under such sentence.

SEC. 504. MODIFYING MEDICARE DURABLE MEDICAL EQUIPMENT FACE-TO-FACE ENCOUNTER DOCUMENTATION REQUIREMENT.

(a) IN GENERAL.—Section 1834(a)(11)(B)(ii) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)(ii)) is amended—

(1) by striking ''the physician documenting that''; and

(2) by striking ''has had a face-to-face encounter'' and inserting ''documenting such physician, physician assistant, practitioner, or specialist has had a face-to-face encounter''.

(b) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by subsection (a) by program instruction or otherwise.

SEC. 505. REDUCING IMPROPER MEDICARE PAYMENTS.

(a) MEDICARE ADMINISTRATIVE CONTRACTOR IMPROPER PAYMENT OUTREACH AND EDUCATION PROGRAM.—Section 1874A of the Social Security Act (42 U.S.C. 1395kk–1) is amended—

(1) in subsection (a)(4)—

(A) by redesignating subparagraph (G) as subparagraph (H); and

(B) by inserting after subparagraph (F) the following new subparagraph:

''(G) IMPROPER PAYMENT OUTREACH AND EDUCATION PROGRAM.—Having in place an improper payment outreach and education program described in subsection (h).''; and

(2) by adding at the end the following new subsection:

''(h) IMPROPER PAYMENT OUTREACH AND EDUCATION PROGRAM.—

''(1) IN GENERAL.—In order to reduce improper payments under this title, each medicare administrative contractor shall establish and have in place an improper payment outreach and education program under which the contractor, through outreach, education, training, and technical assistance or other activities, shall provide providers of services and suppliers located in the region covered by the contract under this section with the information described in paragraph (2). The activities described in the preceding sentence shall be conducted on a regular basis.

''(2) INFORMATION TO BE PROVIDED THROUGH ACTIVITIES.—The information to be provided under such payment outreach and education program shall include information the Secretary determines to be appropriate, which may include the following information:

''(A) A list of the providers' or suppliers' most frequent and expensive payment errors over the last quarter.

''(B) Specific instructions regarding how to correct or avoid such errors in the future.

''(C) A notice of new topics that have been approved by the Secretary for audits conducted by recovery audit contractors under section 1893(h).

''(D) Specific instructions to prevent future issues related to such new audits.

''(E) Other information determined appropriate by the Secretary.

''(3) PRIORITY.—A medicare administrative contractor shall give priority to activities under such program that will reduce improper payments that are one or more of the following:

''(A) Are for items and services that have the highest rate of improper payment.

''(B) Are for items and service that have the greatest total dollar amount of improper payments.

''(C) Are due to clear misapplication or misinterpretation of Medicare policies.

''(D) Are clearly due to common and inadvertent clerical or administrative errors.

''(E) Are due to other types of errors that the Secretary determines could be prevented through activities under the program.

''(4) INFORMATION ON IMPROPER PAYMENTS FROM RECOVERY AUDIT CONTRACTORS.—

''(A) IN GENERAL.—In order to assist medicare administrative contractors in carrying out improper payment outreach and education programs, the Secretary shall provide each contractor with a complete list of the types of improper payments identified by recovery audit contractors under section 1893(h) with respect to providers of services and suppliers located in the region covered by the contract under this section. Such information shall be provided on a time frame the Secretary determines appropriate which may be on a quarterly basis.

''(B) INFORMATION.—The information described in subparagraph (A) shall include information such as the following:

''(i) Providers of services and suppliers that have the highest rate of improper payments.

''(ii) Providers of services and suppliers that have the greatest total dollar amounts of improper payments.

''(iii) Items and services furnished in the region that have the highest rates of improper payments.

''(iv) Items and services furnished in the region that are responsible for the greatest total dollar amount of improper payments.

''(v) Other information the Secretary determines would assist the contractor in carrying out the program.

''(5) COMMUNICATIONS.—Communications with providers of services and suppliers under an improper payment outreach and education program are subject to the standards and requirements of subsection (g).''.

(b) USE OF CERTAIN FUNDS RECOVERED BY RACS.—Section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) is amended—

(1) in paragraph (2), by inserting ''or paragraph (10)'' after ''paragraph (1)(C)''; and

(2) by adding at the end the following new paragraph:

''(10) USE OF CERTAIN RECOVERED FUNDS.—

''(A) IN GENERAL.—After application of paragraph (1)(C), the Secretary shall retain a portion of the amounts recovered by recovery audit contractors for each year under this section which shall be available to the program management account of the Centers for Medicare & Medicaid Services for purposes of, subject to subparagraph (B), carrying out sections 1833(z), 1834(l)(16), and 1874A(a)(4)(G), carrying out section 514(b) of the Medicare Access and CHIP Reauthorization Act of 2015, and implementing strategies (such as claims processing edits) to help reduce the error rate of payments under this title. The amounts retained under the preceding sentence shall not exceed an amount equal to 15 percent of the amounts recovered under this subsection, and shall remain available until expended.

''(B) LIMITATION.—Except for uses that support claims processing (including edits) or system functionality for detecting fraud, amounts retained under subparagraph (A) may not be used for technological-related infrastructure, capital investments, or information systems.

''(C) NO REDUCTION IN PAYMENTS TO RECOVERY AUDIT CONTRACTORS.—Nothing in subparagraph (A) shall reduce amounts available for payments to recovery audit contractors under this subsection.''.

SEC. 506. IMPROVING SENIOR MEDICARE PATROL AND FRAUD REPORTING REWARDS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop a plan to revise the incentive program under section 203(b) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1395b–5(b)) to encourage greater participation by individuals to report fraud and abuse in the Medicare program. Such plan shall include recommendations for—

(1) ways to enhance rewards for individuals reporting under the incentive program, including rewards based on information that leads to an administrative action; and

(2) extending the incentive program to the Medicaid program.

(b) PUBLIC AWARENESS AND EDUCATION CAMPAIGN.—The plan developed under subsection (a) shall also include recommendations for the use of the Senior Medicare Patrols authorized under section 411 of the Older Americans Act of 1965 (42 U.S.C. 3032) to conduct a public awareness and education campaign to encourage participation in the revised incentive program under subsection (a).

(c) SUBMISSION OF PLAN.—Not later than 180 days after the date of enactment of this Act, the Secretary shall submit to Congress the plan developed under subsection (a).

SEC. 507. REQUIRING VALID PRESCRIBER NATIONAL PROVIDER IDENTIFIERS ON PHARMACY CLAIMS.

Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended by adding at the end the following new paragraph:

''(4) REQUIRING VALID PRESCRIBER NATIONAL PROVIDER IDENTIFIERS ON PHARMACY CLAIMS.—

''(A) IN GENERAL.—For plan year 2016 and subsequent plan years, the Secretary shall require a claim for a covered part D drug for a part D eligible individual enrolled in a prescription drug plan under this part or an MA–PD plan under part C to include a prescriber National Provider Identifier that is determined to be valid under the procedures established under subparagraph (B)(i).

''(B) PROCEDURES.—

''(i) VALIDITY OF PRESCRIBER NATIONAL PROVIDER IDENTIFIERS.—The Secretary, in consultation with appropriate stakeholders, shall establish procedures for determining the validity of prescriber National Provider Identifiers under subparagraph (A).

''(ii) INFORMING BENEFICIARIES OF REASON FOR DENIAL.—The Secretary shall establish procedures to ensure that, in the case that a claim for a covered part D drug of an individual described in subparagraph (A) is denied because the claim does not meet the requirements of this paragraph, the individual is properly informed at the point of service of the reason for the denial.

''(C) REPORT.—Not later than January 1, 2018, the Inspector General of the Department of Health and Human Services shall submit to Congress a report on the effectiveness of the procedures established under subparagraph (B)(i).''.

SEC. 508. OPTION TO RECEIVE MEDICARE SUMMARY NOTICE ELECTRONICALLY.

(a) IN GENERAL.—Section 1806 of the Social Security Act (42 U.S.C. 1395b–7) is amended by adding at the end the following new subsection:

''(c) FORMAT OF STATEMENTS FROM SECRETARY.—

''(1) ELECTRONIC OPTION BEGINNING IN 2016.—Subject to paragraph (2), for statements described in subsection (a) that are furnished for a period in 2016 or a subsequent year, in the case that an individual described in subsection (a) elects, in accordance with such form, manner, and time specified by the Secretary, to receive such statement in an electronic format, such statement shall be furnished to such individual for each period subsequent to such election in such a format and shall not be mailed to the individual.

''(2) LIMITATION ON REVOCATION OPTION.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary may determine a maximum number of elections described in paragraph (1) by an individual that may be revoked by the individual.

''(B) MINIMUM OF ONE REVOCATION OPTION.—In no case may the Secretary determine a maximum number under subparagraph (A) that is less than one.

''(3) NOTIFICATION.—The Secretary shall ensure that, in the most cost effective manner and beginning January 1, 2017, a clear notification of the option to elect to receive statements described in subsection (a) in an electronic format is made available, such as through the notices distributed under section 1804, to individuals described in subsection (a).''.

(b) ENCOURAGED EXPANSION OF ELECTRONIC STATEMENTS.—To the extent to which the

Secretary of Health and Human Services determines appropriate, the Secretary shall—

(1) apply an option similar to the option described in subsection (c)(1) of section 1806 of the Social Security Act (42 U.S.C. 1395b–7) (relating to the provision of the Medicare Summary Notice in an electronic format), as added by subsection (a), to other statements and notifications under title XVIII of such Act (42 U.S.C. 1395 et seq.); and

(2) provide such Medicare Summary Notice and any such other statements and notifications on a more frequent basis than is otherwise required under such title.

SEC. 509. RENEWAL OF MAC CONTRACTS.

(a) IN GENERAL.—Section 1874A(b)(1)(B) of the Social Security Act (42 U.S.C. 1395kk–1(b)(1)(B)) is amended by striking ''5 years'' and inserting ''10 years''.

(b) APPLICATION.—The amendments made by subsection (a) shall apply to contracts entered into on or after, and to contracts in effect as of, the date of the enactment of this Act.

(c) CONTRACTOR PERFORMANCE TRANSPARENCY.—Section 1874A(b)(3)(A) of the Social Security Act (42 U.S.C. 1395kk–1(b)(3)(A)) is amended by adding at the end the following new clause:

''(iv) CONTRACTOR PERFORMANCE TRANSPARENCY.—To the extent possible without compromising the process for entering into and renewing contracts with medicare administrative contractors under this section, the Secretary shall make available to the public the performance of each medicare administrative contractor with respect to such performance requirements and measurement standards.''.

SEC. 510. STUDY ON PATHWAY FOR INCENTIVES TO STATES FOR STATE PARTICIPATION IN MEDICAID DATA MATCH PROGRAM.

Section 1893(g) of the Social Security Act (42 U.S.C. 1395ddd(g)) is amended by adding at the end the following new paragraph:

''(3) INCENTIVES FOR STATES.—The Secretary shall study and, as appropriate, may specify incentives for States to work with the Secretary for the purposes described in paragraph (1)(A)(ii). The application of the previous sentence may include use of the waiver authority described in paragraph (2).''.

SEC. 511. GUIDANCE ON APPLICATION OF COMMON RULE TO CLINICAL DATA REGISTRIES.

Not later than one year after the date of the enactment of this section, the Secretary of Health and Human Services shall issue a clarification or modification with respect to the application of subpart A of part 46 of title 45, Code of Federal Regulations, governing the protection of human subjects in research (and commonly known as the ''Common Rule''), to activities, including quality improvement activities, involving clinical data registries, including entities that are qualified clinical data registries pursuant to section 1848(m)(3)(E) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(E)).

SEC. 512. ELIMINATING CERTAIN CIVIL MONEY PENALTIES; GAINSHARING STUDY AND REPORT.

(a) ELIMINATING CIVIL MONEY PENALTIES FOR INDUCEMENTS TO PHYSICIANS TO LIMIT SERVICES THAT ARE NOT MEDICALLY NECESSARY.—

(1) IN GENERAL.—Section 1128A(b)(1) of the Social Security Act (42 U.S.C. 1320a–7a(b)(1)) is amended by inserting ''medically necessary'' after ''reduce or limit''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to payments made on or after the date of the enactment of this Act.

(b) GAINSHARING STUDY AND REPORT.—Not later than 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with the Inspector General of the Department of Health and Human Services, shall submit to Congress a report with options for amending existing fraud and abuse laws in, and regulations related to, titles XI and XVIII of the Social Security Act (42 U.S.C. 301 et seq.), through exceptions, safe harbors, or other narrowly targeted provisions, to permit gainsharing arrangements that otherwise would be subject to the civil money penalties described in paragraphs (1) and (2) of section 1128A(b) of such Act (42 U.S.C. 1320a–7a(b)), or similar arrangements between physicians and hospitals, and that improve care while reducing waste and increasing efficiency. The report shall—

(1) consider whether such provisions should apply to ownership interests, compensation arrangements, or other relationships;

(2) describe how the recommendations address accountability, transparency, and quality, including how best to limit inducements to stint on care, discharge patients prematurely, or otherwise reduce or limit medically necessary care; and

(3) consider whether a portion of any savings generated by such arrangements (as compared to an historical benchmark or other metric specified by the Secretary to determine the impact of delivery and payment system changes under such title XVIII on expenditures made under such title) should accrue to the Medicare program under title XVIII of the Social Security Act.

SEC. 513. MODIFICATION OF MEDICARE HOME HEALTH SURETY BOND CONDITION OF PARTICIPATION REQUIREMENT.

Section 1861(o)(7) of the Social Security Act (42 U.S.C. 1395x(o)(7)) is amended to read as follows:

''(7) provides the Secretary with a surety bond—

''(A) in a form specified by the Secretary and in an amount that is not less than the minimum of $50,000; and

''(B) that the Secretary determines is commensurate with the volume of payments to the home health agency; and''.

SEC. 514. OVERSIGHT OF MEDICARE COVERAGE OF MANUAL MANIPULATION OF THE SPINE TO CORRECT SUBLUXATION.

(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

''(z) MEDICAL REVIEW OF SPINAL SUBLUXATION SERVICES.—

''(1) IN GENERAL.—The Secretary shall implement a process for the medical review (as described in paragraph (2)) of treatment by a chiropractor described in section 1861(r)(5) by means of manual manipulation of the spine to correct a subluxation (as described in such section) of an individual who is enrolled under this part and apply such process to such services furnished on or after January 1, 2017, focusing on services such as—

''(A) services furnished by a such a chiropractor whose pattern of billing is aberrant compared to peers; and

''(B) services furnished by such a chiropractor who, in a prior period, has a services denial percentage in the 85th percentile or greater, taking into consideration the extent that service denials are overturned on appeal.

''(2) MEDICAL REVIEW.—

''(A) PRIOR AUTHORIZATION MEDICAL REVIEW.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall use prior authorization medical review for services described in paragraph (1) that are furnished to an individual by a chiropractor described in section 1861(r)(5) that are part of an episode of treatment that includes more than 12 services. For purposes of the preceding sentence, an episode of treatment shall be determined by the underlying cause that justifies the need for services, such as a diagnosis code.

''(ii) ENDING APPLICATION OF PRIOR AUTHORIZATION MEDICAL REVIEW.—The Secretary shall end the application of prior authorization medical review under clause (i) to services described in paragraph (1) by such a chiropractor if the Secretary determines that the chiropractor has a low denial rate under such prior authorization medical review. The Secretary may subsequently reapply prior authorization medical review to such chiropractor if the Secretary determines it to be appropriate and the chiropractor has, in the time period subsequent to the determination by the Secretary of a low denial rate with respect to the chiropractor, furnished such services described in paragraph (1).

''(iii) EARLY REQUEST FOR PRIOR AUTHORIZATION REVIEW PERMITTED.—Nothing in this subsection shall be construed to prevent such a chiropractor from requesting prior authorization for services described in paragraph (1) that are to be furnished to an individual before the chiropractor furnishes the twelfth such service to such individual for an episode of treatment.

''(B) TYPE OF REVIEW.—The Secretary may use pre-payment review or post-payment review of services described in section 1861(r)(5) that are not subject to prior authorization medical review under subparagraph (A).

''(C) RELATIONSHIP TO LAW ENFORCEMENT ACTIVITIES.—The Secretary may determine that medical review under this subsection does not apply in the case where potential fraud may be involved.

''(3) NO PAYMENT WITHOUT PRIOR AUTHORIZATION.—With respect to a service described in paragraph (1) for which prior authorization medical review under this subsection applies, the following shall apply:

''(A) PRIOR AUTHORIZATION DETERMINATION.—The Secretary shall make a determination, prior to the service being furnished, of whether the service would or would not meet the applicable requirements of section 1862(a)(1)(A).

''(B) DENIAL OF PAYMENT.—Subject to paragraph (5), no payment may be made under this part for the service unless the Secretary determines pursuant to subparagraph (A) that the service would meet the applicable requirements of such section 1862(a)(1)(A).

''(4) SUBMISSION OF INFORMATION.—A chiropractor described in section 1861(r)(5) may submit the information necessary for medical review by fax, by mail, or by electronic means. The Secretary shall make available the electronic means described in the preceding sentence as soon as practicable.

''(5) TIMELINESS.—If the Secretary does not make a prior authorization determination under paragraph (3)(A) within 14 business days of the date of the receipt of medical documentation needed to make such determination, paragraph (3)(B) shall not apply.

''(6) APPLICATION OF LIMITATION ON BENEFICIARY LIABILITY.—Where payment may not be made as a result of the application of paragraph (2)(B), section 1879 shall apply in the same manner as such section applies to a denial that is made by reason of section 1862(a)(1).

''(7) REVIEW BY CONTRACTORS.—The medical review described in paragraph (2) may be conducted by medicare administrative contractors pursuant to section 1874A(a)(4)(G) or by any other contractor determined appropriate by the Secretary that is not a recovery audit contractor.

''(8) MULTIPLE SERVICES.—The Secretary shall, where practicable, apply the medical review under this subsection in a manner so as to allow an individual described in paragraph (1) to obtain, at a single time rather

than on a service-by-service basis, an authorization in accordance with paragraph (3)(A) for multiple services.

''(9) CONSTRUCTION.—With respect to a service described in paragraph (1) that has been affirmed by medical review under this subsection, nothing in this subsection shall be construed to preclude the subsequent denial of a claim for such service that does not meet other applicable requirements under this Act.

''(10) IMPLEMENTATION.—

''(A) AUTHORITY.—The Secretary may implement the provisions of this subsection by interim final rule with comment period.

''(B) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to medical review under this subsection.''.

(b) IMPROVING DOCUMENTATION OF SERVICES.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall, in consultation with stakeholders (including the American Chiropractic Association) and representatives of medicare administrative contractors (as defined in section 1874A(a)(3)(A) of the Social Security Act (42 U.S.C. 1395kk–1(a)(3)(A))), develop educational and training programs to improve the ability of chiropractors to provide documentation to the Secretary of services described in section 1861(r)(5) in a manner that demonstrates that such services are, in accordance with section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)), reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

(2) TIMING.—The Secretary shall make the educational and training programs described in paragraph (1) publicly available not later than January 1, 2016.

(3) FUNDING.—The Secretary shall use funds made available under paragraph (10) of section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)), as added by section 505, to carry out this subsection.

(c) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the effectiveness of the process for medical review of services furnished as part of a treatment by means of manual manipulation of the spine to correct a subluxation implemented under subsection (z) of section 1833 of the Social Security Act (42 U.S.C. 1395l), as added by subsection (a). Such study shall include an analysis of—

(A) aggregate data on—

(i) the number of individuals, chiropractors, and claims for services subject to such review; and

(ii) the number of reviews conducted under such section; and

(B) the outcomes of such reviews.

(2) REPORT.—Not later than four years after the date of enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under paragraph (1), including recommendations for such legislation and administrative action with respect to the process for medical review implemented under subsection (z) of section 1833 of the Social Security Act (42 U.S.C. 1395l) as the Comptroller General determines appropriate.

SEC. 515. NATIONAL EXPANSION OF PRIOR AUTHORIZATION MODEL FOR REPETITIVE SCHEDULED NON-EMERGENT AMBULANCE TRANSPORT.

(a) INITIAL EXPANSION.—

(1) IN GENERAL.—In implementing the model described in paragraph (2) proposed to be tested under subsection (b) of section 1115A of the Social Security Act (42 U.S.C. 1315a), the Secretary of Health and Human Services shall revise the testing under subsection (b) of such section to cover, effective not later than January 1, 2016, States located in medicare administrative contractor (MAC) regions L and 11 (consisting of Delaware, the District of Columbia, Maryland, New Jersey, Pennsylvania, North Carolina, South Carolina, West Virginia, and Virginia).

(2) MODEL DESCRIBED.—The model described in this paragraph is the testing of a model of prior authorization for repetitive scheduled non-emergent ambulance transport proposed to be carried out in New Jersey, Pennsylvania, and South Carolina.

(3) FUNDING.—The Secretary shall allocate funds made available under section 1115A(f)(1)(B) of the Social Security Act (42 U.S.C. 1315a(f)(1)(B)) to carry out this subsection.

(b) NATIONAL EXPANSION.—Section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)) is amended by adding at the end the following new paragraph:

''(16) PRIOR AUTHORIZATION FOR REPETITIVE SCHEDULED NON-EMERGENT AMBULANCE TRANSPORTS.—

''(A) IN GENERAL.—Beginning January 1, 2017, if the expansion to all States of the model of prior authorization described in paragraph (2) of section 515(a) of the Medicare Access and CHIP Reauthorization Act of 2015 meets the requirements described in paragraphs (1) through (3) of section 1115A(c), then the Secretary shall expand such model to all States.

''(B) FUNDING.—The Secretary shall use funds made available under section 1893(h)(10) to carry out this paragraph.

''(C) CLARIFICATION REGARDING BUDGET NEUTRALITY.—Nothing in this paragraph may be construed to limit or modify the application of section 1115A(b)(3)(B) to models described in such section, including with respect to the model described in subparagraph (A) and expanded beginning on January 1, 2017, under such subparagraph.''.

SEC. 516. REPEALING DUPLICATIVE MEDICARE SECONDARY PAYOR PROVISION.

(a) IN GENERAL.—Section 1862(b)(5) of the Social Security Act (42 U.S.C. 1395y(b)(5)) is amended by inserting at the end the following new subparagraph:

''(E) END DATE.—The provisions of this paragraph shall not apply to information required to be provided on or after July 1, 2016.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall apply to information required to be provided on or after January 1, 2016.

SEC. 517. PLAN FOR EXPANDING DATA IN ANNUAL CERT REPORT.

Not later than June 30, 2015, the Secretary of Health and Human Services shall submit to the Committee on Finance of the Senate, and to the Committees on Energy and Commerce and Ways and Means of the House of Representatives—

(1) a plan for including, in the annual report of the Comprehensive Error Rate Testing (CERT) program, data on services (or groupings of services) (other than medical visits) paid under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) where the fee schedule amount is in excess of $250 and where the error rate is in excess of 20 percent; and

(2) to the extent practicable by such date, specific examples of services described in paragraph (1).

SEC. 518. REMOVING FUNDS FOR MEDICARE IMPROVEMENT FUND ADDED BY IMPACT ACT OF 2014.

Section 1898(b)(1) of the Social Security Act (42 U.S.C. 1395iii(b)(1)), as amended by section 3(e)(3) of the IMPACT Act of 2014 (Public Law 113–185), is amended by striking ''$195,000,000'' and inserting ''$0''.

SEC. 519. RULE OF CONSTRUCTION.

Except as explicitly provided in this subtitle, nothing in this subtitle, including the amendments made by this subtitle, shall be construed as preventing the use of notice and comment rulemaking in the implementation of the provisions of, and the amendments made by, this subtitle.

Subtitle B—Other Provisions

SEC. 521. EXTENSION OF TWO-MIDNIGHT PAMA RULES ON CERTAIN MEDICAL REVIEW ACTIVITIES.

Section 111 of the Protecting Access to Medicare Act of 2014 (Public Law 113–93; 42 U.S.C. 1395ddd note) is amended—

(1) in subsection (a), by striking ''the first 6 months of fiscal year 2015'' and inserting ''through the end of fiscal year 2015'';

(2) in subsection (b), by striking ''March 31, 2015'' and inserting ''September 30, 2015''; and

(3) by adding at the end the following new subsection:

''(c) CONSTRUCTION.—Except as provided in subsections (a) and (b), nothing in this section shall be construed as limiting the Secretary's authority to pursue fraud and abuse activities under such section 1893(h) or otherwise.''.

SEC. 522. REQUIRING BID SURETY BONDS AND STATE LICENSURE FOR ENTITIES SUBMITTING BIDS UNDER THE MEDICARE DMEPOS COMPETITIVE ACQUISITION PROGRAM.

(a) BID SURETY BONDS.—Section 1847(a)(1) of the Social Security Act (42 U.S.C. 1395w–3(a)(1)) is amended by adding at the end the following new subparagraphs:

''(G) REQUIRING BID BONDS FOR BIDDING ENTITIES.—With respect to rounds of competitions beginning under this subsection for contracts beginning not earlier than January 1, 2017, and not later than January 1, 2019, an entity may not submit a bid for a competitive acquisition area unless, as of the deadline for bid submission, the entity has obtained (and provided the Secretary with proof of having obtained) a bid surety bond (in this paragraph referred to as a 'bid bond') in a form specified by the Secretary consistent with subparagraph (H) and in an amount that is not less than $50,000 and not more than $100,000 for each competitive acquisition area in which the entity submits the bid.

''(H) TREATMENT OF BID BONDS SUBMITTED.—

''(i) FOR BIDDERS THAT SUBMIT BIDS AT OR BELOW THE MEDIAN AND ARE OFFERED BUT DO NOT ACCEPT THE CONTRACT.—In the case of a bidding entity that is offered a contract for any product category for a competitive acquisition area, if—

''(I) the entity's composite bid for such product category and area was at or below the median composite bid rate for all bidding entities included in the calculation of the single payment amounts for such product category and area; and

''(II) the entity does not accept the contract offered for such product category and area,

the bid bond submitted by such entity for such area shall be forfeited by the entity and the Secretary shall collect on it.

''(ii) TREATMENT OF OTHER BIDDERS.—In the case of a bidding entity for any product category for a competitive acquisition area, if the entity does not meet the bid forfeiture conditions in subclauses (I) and (II) of clause (i) for any product category for such area, the bid bond submitted by such entity for such area shall be returned within 90 days of the public announcement of the contract suppliers for such area.''.

(b) STATE LICENSURE.—

(1) IN GENERAL.—Section 1847(b)(2)(A) of the Social Security Act (42 U.S.C. 1395w–3(b)(2)(A)) is amended by adding at the end the following new clause:

''(v) The entity meets applicable State licensure requirements.''.

(2) CONSTRUCTION.—Nothing in the amendment made by paragraph (1) shall be construed as affecting the authority of the Secretary of Health and Human Services to require State licensure of an entity under the Medicare competitive acquisition program under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) before the date of the enactment of this Act.

(c) GAO REPORT ON BID BOND IMPACT ON SMALL SUPPLIERS.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study that evaluates the effect of the bid surety bond requirement under the amendment made by subsection (a) on the participation of small suppliers in the Medicare DMEPOS competitive acquisition program under section 1847 of the Social Security Act (42 U.S.C. 1395w–3).

(2) REPORT.—Not later than 6 months after the date contracts are first awarded subject to such bid surety bond requirement, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). Such report shall include recommendations for changes in such requirement in order to ensure robust participation by legitimate small suppliers in the Medicare DMEPOS competition acquisition program.

SEC. 523. PAYMENT FOR GLOBAL SURGICAL PACKAGES.

(a) IN GENERAL.—Section 1848(c) of the Social Security Act (42 U.S.C. 1395w–4(c)) is amended by adding at the end the following new paragraph:

''(8) GLOBAL SURGICAL PACKAGES.—

''(A) PROHIBITION OF IMPLEMENTATION OF RULE REGARDING GLOBAL SURGICAL PACKAGES.—

''(i) IN GENERAL.—The Secretary shall not implement the policy established in the final rule published on November 13, 2014 (79 Fed. Reg. 67548 et seq.), that requires the transition of all 10-day and 90-day global surgery packages to 0-day global periods.

''(ii) CONSTRUCTION.—Nothing in clause (i) shall be construed to prevent the Secretary from revaluing misvalued codes for specific surgical services or assigning values to new or revised codes for surgical services.

''(B) COLLECTION OF DATA ON SERVICES INCLUDED IN GLOBAL SURGICAL PACKAGES.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall through rulemaking develop and implement a process to gather, from a representative sample of physicians, beginning not later than January 1, 2017, information needed to value surgical services. Such information shall include the number and level of medical visits furnished during the global period and other items and services related to the surgery and furnished during the global period, as appropriate. Such information shall be reported on claims at the end of the global period or in another manner specified by the Secretary. For purposes of carrying out this paragraph (other than clause (iii)), the Secretary shall transfer from the Federal Supplemental Medical Insurance Trust Fund under section 1841 $2,000,000 to the Center for Medicare & Medicaid Services Program Management Account for fiscal year 2015. Amounts transferred under the previous sentence shall remain available until expended.

''(ii) REASSESSMENT AND POTENTIAL SUNSET.—Every 4 years, the Secretary shall reassess the value of the information collected pursuant to clause (i). Based on such a reassessment and by regulation, the Secretary may discontinue the requirement for collection of information under such clause if the Secretary determines that the Secretary has adequate information from other sources, such as qualified clinical data registries, surgical logs, billing systems or other practice or facility records, and electronic health records, in order to accurately value global surgical services under this section.

''(iii) INSPECTOR GENERAL AUDIT.—The Inspector General of the Department of Health and Human Services shall audit a sample of the information reported under clause (i) to verify the accuracy of the information so reported.

''(C) IMPROVING ACCURACY OF PRICING FOR SURGICAL SERVICES.—For years beginning with 2019, the Secretary shall use the information reported under subparagraph (B)(i) as appropriate and other available data for the purpose of improving the accuracy of valuation of surgical services under the physician fee schedule under this section.''.

(b) INCENTIVE FOR REPORTING INFORMATION ON GLOBAL SURGICAL SERVICES.—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w–4(a)) is amended by adding at the end the following new paragraph:

''(9) INFORMATION REPORTING ON SERVICES INCLUDED IN GLOBAL SURGICAL PACKAGES.—With respect to services for which a physician is required to report information in accordance with subsection (c)(8)(B)(i), the Secretary may through rulemaking delay payment of 5 percent of the amount that would otherwise be payable under the physician fee schedule under this section for such services until the information so required is reported.''.

SEC. 524. EXTENSION OF SECURE RURAL SCHOOLS AND COMMUNITY SELF-DETERMINATION ACT OF 2000.

(a) PAYMENTS FOR FISCAL YEARS 2014 AND 2015.—

(1) PAYMENTS REQUIRED.—Section 101 of the Secure Rural Schools and Community Self-Determination Act of 2000 (16 U.S.C. 7111) is amended by striking ''2013'' both places it appears and inserting ''2015''.

(2) PROMPT PAYMENT.—Payments for fiscal year 2014 under title I of the Secure Rural Schools and Community Self-Determination Act of 2000 (16 U.S.C. 7111 et seq.), as amended by this section, shall be made not later than 45 days after the date of the enactment of this Act.

(3) REDUCTION IN FISCAL YEAR 2014 PAYMENTS ON ACCOUNT OF PREVIOUS 25- AND 50-PERCENT PAYMENTS.—Section 101 of the Secure Rural Schools and Community Self-Determination Act of 2000 (16 U.S.C. 7111) is amended by adding at the end the following new subsection:

''(c) SPECIAL RULE FOR FISCAL YEAR 2014 PAYMENTS.—

''(1) STATE PAYMENT.—If an eligible county in a State that will receive a share of the State payment for fiscal year 2014 has already received, or will receive, a share of the 25-percent payment for fiscal year 2014 distributed to the State before the date of the enactment of this subsection, the amount of the State payment shall be reduced by the amount of that eligible county's share of the 25-percent payment.

''(2) COUNTY PAYMENT.—If an eligible county that will receive a county payment for fiscal year 2014 has already received a 50-percent payment for that fiscal year, the amount of the county payment shall be reduced by the amount of the 50-percent payment.''.

(4) SHARES OF CALIFORNIA STATE PAYMENT.—Section 103(d)(2) of the Secure Rural Schools and Community Self-Determination Act of 2000 (16 U.S.C. 7113(d)(2)) is amended by striking ''2013'' and inserting ''2015''.

(b) USE OF FISCAL YEAR 2013 ELECTIONS AND RESERVATIONS FOR FISCAL YEARS 2014 AND 2015.—Section 102 of the Secure Rural Schools and Community Self-Determination Act of 2000 (16 U.S.C. 7112) is amended—

(1) in subsection (b)(1), by adding at the end the following new subparagraph:

''(C) EFFECT OF LATE PAYMENT FOR FISCAL YEARS 2014 AND 2015.—The election otherwise required by subparagraph (A) shall not apply for fiscal year 2014 or 2015.'';

(2) in subsection (b)(2)—

(A) in subparagraph (A), by adding at the end the following new sentence: ''If such two-fiscal year period included fiscal year 2013, the county election to receive a share of the 25-percent payment or 50-percent payment, as applicable, also shall be effective for fiscal years 2014 and 2015.''; and

(B) in subparagraph (B), by striking ''2013'' the second place it appears and inserting ''2015''; and

(3) in subsection (d)—

(A) by adding at the end of paragraph (1) the following new subparagraph:

''(E) EFFECT OF LATE PAYMENT FOR FISCAL YEAR 2014.—The election made by an eligible county under subparagraph (B), (C), or (D) for fiscal year 2013, or deemed to be made by the county under paragraph (3)(B) for that fiscal year, shall be effective for fiscal years 2014 and 2015.''; and

(B) by adding at the end of paragraph (3) the following new subparagraph:

''(C) EFFECT OF LATE PAYMENT FOR FISCAL YEAR 2014.—This paragraph does not apply for fiscal years 2014 and 2015.''.

(c) SPECIAL PROJECTS ON FEDERAL LAND.—Title II of the Secure Rural Schools and Community Self-Determination Act of 2000 (16 U.S.C. 7121 et seq.) is amended—

(1) in section 203(a)(1) (16 U.S.C. 7123(a)(1)), by striking ''September 30 for fiscal year 2008 (or as soon thereafter as the Secretary concerned determines is practicable), and each September 30 thereafter for each succeeding fiscal year through fiscal year 2013'' and inserting ''September 30 of each fiscal year (or a later date specified by the Secretary concerned for the fiscal year)'';

(2) in section 204(e)(3)(B)(iii) (16 U.S.C. 7124(e)(3)(B)(iii)), by striking ''each of fiscal years 2010 through 2013'' and inserting ''fiscal year 2010 and fiscal years thereafter'';

(3) in section 207(a) (16 U.S.C. 7127(a)), by striking ''September 30, 2008 (or as soon thereafter as the Secretary concerned determines is practicable), and each September 30 thereafter for each succeeding fiscal year through fiscal year 2013'' and inserting ''September 30 of each fiscal year (or a later date specified by the Secretary concerned for the fiscal year)''; and

(4) in section 208 (16 U.S.C. 7128)—

(A) in subsection (a), by striking ''2013'' and inserting ''2017''; and

(B) in subsection (b), by striking ''2014'' and inserting ''2018''.

(d) COUNTY FUNDS.—Section 304 of the Secure Rural Schools and Community Self-Determination Act of 2000 (16 U.S.C. 7144) is amended—

(1) in subsection (a), by striking ''2013'' and inserting ''2017''; and

(2) in subsection (b), by striking ''2014'' and inserting ''2018''.

(e) AUTHORIZATION OF APPROPRIATIONS.—Section 402 of the Secure Rural Schools and Community Self-Determination Act of 2000 (16 U.S.C. 7152) is amended by striking ''for each of fiscal years 2008 through 2013''.

SEC. 525. EXCLUSION FROM PAYGO SCORECARDS.

(a) STATUTORY PAY-AS-YOU-GO SCORECARDS.—The budgetary effects of this Act shall not be entered on either PAYGO scorecard maintained pursuant to section 4(d) of the Statutory Pay-As-You-Go Act of 2010.

(b) SENATE PAYGO SCORECARDS.—The budgetary effects of this Act shall not be entered on any PAYGO scorecard maintained for purposes of section 201 of S. Con. Res. 21 (110th Congress).

The SPEAKER pro tempore. The bill shall be debatable for 1 hour, equally divided among and controlled by the chair and ranking minority member of the Committee on Energy and Commerce and the chair and ranking minority member of the Committee on Ways and Means.

The gentleman from Pennsylvania (Mr. PITTS), the gentleman from New Jersey (Mr. PALLONE), the gentleman from Texas (Mr. BRADY), and the gentleman from Michigan (Mr. LEVIN) each will control 15 minutes.

The Chair recognizes the gentleman from Pennsylvania.

GENERAL LEAVE

Mr. PITTS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and to include extraneous material on H.R. 2.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Pennsylvania?

There was no objection.

□ 1015

Mr. PITTS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015, sponsored by Congressman BURGESS of Texas.

Mr. Speaker, I rise in support of H.R. 2, the bill I just referenced. Four years ago, upon taking leadership of the Energy and Commerce Health Subcommittee, I made it one of my goals to end the patchwork of doc fixes and repeal the sustainable growth rate.

Now, we are here on the floor of the House with a bipartisan policy and a bipartisan set of pay-fors. There are many who thought that this day would never come.

We are replacing the SGR, once and for all, with a system that allows greater freedom for physicians to practice medicine. We do this without threatening access to health care for seniors. Instead of unrealistic price controls, we are instituting a cooperative process to make our healthcare dollars go farther.

We are also replacing a portion of the projected savings with real entitlement reforms, reforms that could reduce spending by $295 billion in the coming decades.

Let's not make the mistake of saying that this is saving Medicare. The bill makes important reforms that put the program on a better path, but there is much work to do before we achieve that goal.

Future generations of Americans have understandable doubts about whether Medicare will be there when they retire. They pay into the program just as my generation did, but the current system of funding the program will not deliver on that promise for them. The extraordinary progress represented by the bill before us today is the result of a vision for the future and years of hard work.

That vision was wholeheartedly supported by Speaker BOEHNER, and there are many more to thank: Chairman UPTON, for his persistence in leadership; current Ranking Member PALLONE and former Ranking Member Waxman for working with us to get a policy we could all agree on; also Dr. BURGESS, the primary sponsor of today's bill and the vice chairman of the Health Subcommittee in the two past Congresses.

I would especially like to thank the dedicated staff that spent countless hours and sacrificed weekends to make this happen: Dr. John O'Shea, Robert Horne, Josh Trent, Clay Alspach, Michelle Rosenberg, Heidi Stirrup, and Monica Volente, on my personal staff.

Finally, we should see this bill as a first step toward strengthening and saving Medicare. This can't be the end of the road.

Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in strong support of H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015.

For more than 10 years, Congress has had to temporarily fix the flawed sustainable growth rate, SGR, nearly 20 times since it was enacted. Well, today is the last time I will have to talk about the broken SGR. The House has come together to fix it once and for all.

This bill is the result of a lot of hard work by the House Energy and Commerce Committee, Ways and Means and Senate Finance Committees and our leadership. Many of our Members have made important contributions to this bill, and I want to thank them all for being so diligent.

This bill not only repeals the SGR, it replaces it with a reformed system that pays providers based on quality and value. It rewards health outcomes. It allows providers to give more focus to their patients, and most importantly, it provides stability and predictability to the Medicare Program for years to come. This is good for doctors, and it is good for seniors.

This bill also extends critical funding for programs that improve the health and welfare of millions of children, families, and seniors. It makes permanent the qualified individual program which helps low-income seniors pay their Medicare part B premiums.

It makes permanent the Transitional Medical Assistance program, which allows low-income families to maintain their Medicaid coverage for up to 1 year as they transition from welfare to work.

It includes $8 billion in funding for community health centers, the National Health Service Corps, and teaching health centers. This funding will help serve 28 million patients, and all three, together, strengthen access to primary and preventative health care in communities throughout America.

The bill includes a fully funded 2-year extension of CHIP, maintaining all of the improvements in the Affordable Care Act, but this is not just a 2-year extension; it is a robust extension. It keeps the promise made to States by maintaining the 23 percent bump in Federal matching rates and ensures that States, in turn, keep their promise to CHIP kids by leaving maintenance of effort requirements for child enrollment through 2019 untouched.

This bill is not perfect. I wish my Republican colleagues would have agreed to fund CHIP for 4 years. I also remain concerned about the provisions that affect Medicare beneficiaries, but such is the nature of compromise.

Mr. Speaker, I am proud of the work of my committee and of both of our leaderships. This agreement took courage from both sides, but what we have accomplished is truly significant. It is balanced and a thoughtful product, and I urge Members to support it.

I reserve the balance of my time.

Mr. PITTS. Mr. Speaker, I am pleased to yield 1 minute to the gentleman from Mississippi (Mr. HARPER), an outstanding member of the Energy and Commerce Committee and a good advocate on health issues.

Mr. HARPER. Mr. Speaker, the Medicare Access and CHIP Reauthorization Act represents years of bipartisan effort to eliminate the fatally flawed sustainable growth rate formula and implement new payment and delivery models that will promote higher-quality care while reducing costs.

In addition to stabilizing the Medicare Program for our Nation's seniors, the bill addresses the healthcare needs of children and low-income Americans, while promoting the long-term sustainability of the Medicare Program through significant structural reforms to the Medicare Program.

There is no question, Medicare must be modernized in order to avoid the program's projected financial shortfalls. Republicans and Democrats have worked together to advance a blueprint to begin to place Medicare programs on a sound financial footing for both today's and future retirees.

Now is the time to end this failed policy once and for all and protect access to care for seniors. I urge my colleagues to support this legislation.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. GENE GREEN), the ranking member of our House Subcommittee.

Mr. GENE GREEN of Texas. Mr. Speaker, I thank my colleague for yielding to me, and I appreciate his leadership on this issue and many others in our committee.

I rise in support of H.R. 2, the Medicare Access and CHIP Reauthorization Act. As an original cosponsor of this landmark legislation, I urge my colleagues to support the bill.

H.R. 2 will reform the flawed Medicare physician payment system that will reward quality and value over volume, make reforms to slow the growth of healthcare costs, and extend other critical programs, including the Children's Health Insurance Program and

the funding for community health centers.

Since 2003, Congress has intervened 17 times to prevent steep payment cuts caused by the flawed SGR formula in order to preserve seniors' access to care.

Repealing the SGR is the responsible choice, both fiscally and logically. More money has now been spent on short-term patches than the full cost of the permanent repealing of the SGR.

We are closer than we have ever come to repealing the flawed SGR formula and enacting meaningful reform that will strengthen the Medicare system for generations to come.

I want to highlight the additional 2 years of funding for the community health centers program included in the package. These dedicated mandatory funds will avert an impending fiscal cliff set to take place in September. Without this extension, funding for health centers would be slashed by 70 percent, and 7.4 million patients would lose access to care.

Also included in the agreement are funding for the National Health Service Corps and the teaching health center program. Both programs further the goals of improving and strengthening access to primary and preventative care in our communities.

Like any good bipartisan compromise, the legislation strikes a balance and offers a set of viable solutions that should have broad bipartisan support.

I want to thank Speaker BOEHNER, Leader PELOSI, and my colleagues on the Energy and Commerce Committee and Ways and Means Committee for their leadership in working across the aisle to craft this commonsense, landmark legislation.

Mr. PITTS. Mr. Speaker, I am pleased to yield 1 minute to the gentleman from Indiana (Mr. BUCSHON), a member of the Health Subcommittee.

Mr. BUCSHON. Mr. Speaker, today is a great day for America's seniors. After years of flawed Medicare policy, we are finally creating a stable system that ensures Medicare patients will have access to their doctors.

This new policy will move our Medicare system to one that is based on quality of care that is provided to our Nation's seniors. In fact, for the first time in decades, we actually achieve real structural reforms in the program that will help save this critical program for future seniors.

I would also like to highlight that this legislation repeals CMS' policy to eliminate bundled surgical payments. Eliminating surgical payment bundles would force doctors to spend more time billing CMS that could be used for caring for patients.

I would like to thank Chairman PITTS, and I would also like to congratulate Speaker BOEHNER, Minority Leader PELOSI, Chairman UPTON, and Ranking Member PALLONE for putting politics aside and putting America's seniors first.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from Oregon (Mr. SCHRADER).

Mr. SCHRADER. Mr. Speaker, I thank the gentleman for yielding.

I am proud to be here today to support real bipartisan compromise to finally repeal and replace this flawed SGR formula.

I would like to give my congratulations to Congressman BURGESS and, frankly, former Congresswoman Allyson Schwartz also worked very hard for many years to make this thing a reality.

This long-term solution is going to bring stability to Medicare, so seniors will actually be able to continue to see their doctors. Meanwhile, the bill also allows physicians to focus on value and quality of care rather than quantity of care and extends, of course, the vital CHIP program aiding so many children in this country.

Now, though I would prefer to see this bill completely paid for, like many others in this Chamber, I recognize the nature of compromise means you don't get everything you want, whether you are a House Member or a Senate Member.

I am glad, however, that it has been pointed out that at least part of the cost of this bill is covered by implementing crucial reforms to Medicare that will help improve its solvency for future generations, certainly compared to our current policy.

I congratulate my colleagues on the both sides of the aisle for coming together on this agreement. It is long overdue and will greatly improve our system. I hope we vote for this bill.

Mr. PITTS. Mr. Speaker, I am pleased to yield 1 minute to the gentlewoman from Tennessee (Mrs. BLACKBURN), the vice chair of the Energy and Commerce Committee.

Mrs. BLACKBURN. Mr. Speaker, I want to thank Chairman PITTS for the work that he has done on this, as well as the other members of our committee.

I do rise today in support of H.R. 2.

I think every one of us have constituents who are Medicare enrollees who tell us the stories and the stress that comes with not being able to see a doctor because they are no longer taking Medicare patients.

What this does is go to the heart of the problem, the SGR, the sustainable growth rate. It was a big part of the problem—the sword of Damocles, if you will—because doctors never knew if they were going to get paid or what they were going to get paid or if it was going to be a double-digit or a single-digit cut. Let's get that off the table and provide some certainty.

H.R. 2 is finally going to eliminate the flawed SGR. It will be replaced with commonsense legislation which will provide healthcare providers with the predictability that is necessary to meet the needs of Medicare enrollees.

In addition, H.R. 2 takes an important step to rein in healthcare spending, incentivizing doctors on quality, as opposed to quantity, getting at part of the problem of our entitlement programs.

I congratulate all involved. I encourage a ''yes'' vote.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from New York (Mr. ENGEL).

□ 1030

Mr. ENGEL. Mr. Speaker, I rise in strong support of H.R. 2.

I have always believed that our physician workforce deserves to be fairly compensated. The flawed SGR formula has failed to do this for over a decade, and it isn't right that physicians have faced looming Medicare cuts year after year. Therefore, I am pleased that House Democrats and Republicans have come together to craft a fair, bipartisan compromise to this longstanding and expensive problem.

Mr. Speaker, the American people want us to end gridlock. They want us to meet in the middle, and we are doing that today. I want to commend Speaker BOEHNER and Leader PELOSI. And while I would have liked to have seen a 4-year extension of CHIP funding and I am upset that unnecessary Hyde language has been attached to much-needed community health center funding, overall, this is a good agreement.

Medicare beneficiaries, their physicians, children, and our entire health care system will benefit from seeing CHIP and health center funding extended, SGR repealed, and quality-based physician reimbursement incentivized.

So I urge my colleagues both here in the House and in the Senate to support this compromise legislation, the Medicare Access and CHIP Reauthorization Act of 2015.

Mr. PITTS. Mr. Speaker, I am pleased to yield 1 minute to the gentleman from Tennessee (Mr. ROE), the chairman of the Doctors Caucus, who should be recognized for his tireless efforts to build support for this bill.

Mr. ROE of Tennessee. Mr. Speaker, today I rise in strong support of H.R. 2, which will permanently repeal the flawed SGR formula and replace it with meaningful reform that will ensure seniors' access to Medicare.

This agreement is one of the most important things we have accomplished since I have been in Congress, and I couldn't be prouder of the work done by the House Energy and Commerce and Ways and Means Committees, along with the GOP Doctors Caucus.

I want to give a special thank-you to Speaker JOHN BOEHNER and Leader NANCY PELOSI, without whose leadership this agreement would never have happened.

This bill will ensure Medicare recipients have access to quality care and helps pave the way for entitlement reform by making important structural changes to the program. That is an important point. People over the years

have referred to this as the ''doc fix,'' but it really should be called the ''senior fix.'' The cuts required by SGR were so severe that, had they been allowed to go into effect, seniors' access to a Medicare physician almost assuredly would have been curtailed.

After 12 years, 17 patches, and $170 billion spent to keep a flawed formula from doing lasting damage to Medicare, we are finally acting in a responsible manner, in a way that should give the American people renewed confidence in Congress' ability to act on important matters.

I thank all involved.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentlewoman from California (Ms. PELOSI), our Democratic leader, and I thank her for what she accomplished here today working with the Speaker.

Ms. PELOSI. Mr. Speaker, I thank the gentleman for yielding.

I thank Mr. PALLONE and Mr. LEVIN, our ranking members on the Energy and Commerce Committee and the Ways and Means Committee, for their leadership and cooperation on this issue, as well as Chairman RYAN of the Ways and Means Committee and Chairman UPTON of the Energy and Commerce Committee.

This is a day that we really have to salute our staff. They have worked so hard. It was my honor to work with Speaker BOEHNER on this important issue to do what we came here to do—to legislate. We are the legislative branch. We are legislating. We are working together to get the job done for the American people.

From Speaker BOEHNER's staff, I especially want to thank Charlotte Ivancic, who was extremely knowledgeable about health policy and was smart and fair about all of this. Wendell Primus of my staff was a strong voice for the concerns of seniors and children and the rest in those discussions.

Ed Grossman and his team at House Legislative Counsel—for all the ideas that Members churned up, Legislative Counsel had to translate that into what the possibility was for legislative language. They worked 24/7, weekends included.

Megan O'Reilly, Bridget Taylor, and the technical teams at CMS and HHS worked 24/7 for many days.

Holly Harvey and Tom Bradley and the team at the Congressional Budget Office, having to score every change of idea that we may have had.

Again, the staff both at the Ways and Means Committee and the Energy and Commerce Committee on both sides of the aisle, I take the time to recognize them because in recognizing them, I really want to recognize the work that is done by staff on all that we do here.

All of these individuals, again, have been working 18-hour days for the past few weeks, and we thank them for their tireless hard work.

This package includes many important victories for low-income seniors, children, and families. There are many reasons to support this bill, four of which I would like to point out:

We are strengthening the quality of care for many older Americans with additional funding for initiatives that help low-income seniors pay their Medicare part B premiums.

We have added almost $750 million for training more urgently needed nurses and physicians.

We have secured the health care of poor children with a 2-year extension of the Children's Health Insurance Program at the same rates set by the Affordable Care Act. Many people wanted more, as did I. That does not diminish the importance of the 2-year extension.

Lastly, we have secured critical funding for community health centers over the next 2 years, expanding a vital investment in underserved communities.

I am proud to rise in support of this historic, bipartisan package. It represents bold, necessary progress for our country. And it is not just about enabling our seniors to see their doctors, which was the original purpose of the bill. It is about how we can increase performance and lower cost; it is about value, not volume of service; it is about quality, not quantity of procedures; and this legislation is transformative in how it rewards the value, not the volume. So I am proud to support it.

At long last, we will replace the broken SGR formula and transition Medicare away from a volume-based system toward one that rewards values, ensures the accuracy of payments, and improves the quality of care.

With this legislation, we give America's seniors confidence that they will be able to see the doctors they need and the doctors they like, liberating them and their families from the shadow of needless, annual crises.

And as a woman, during Women's History Month, I am very proud of what the legislation means to women and their health issues.

So for these and other reasons, I urge my colleagues to vote ''aye.''

It was my privilege to work with the Speaker in a bipartisan way on this legislation. I hope it will be a model of things to come.

Mr. PITTS. Mr. Speaker, I join in thanking the minority leader for her role in achieving this bipartisan compromise. It is really historic. I think it is appropriate that this is happening on her birthday, and I join my colleagues in wishing her a happy birthday today.

Mr. Speaker, could I inquire of the time remaining.

The SPEAKER pro tempore. The gentleman from Pennsylvania has 8 minutes remaining. The gentleman from New Jersey has 7½ minutes remaining.

Mr. PITTS. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. BILIRAKIS), another member of the Health Subcommittee.

Mr. BILIRAKIS. Mr. Speaker, I rise today to support H.R. 2, to repeal and replace the SGR.

This bill will replace the SGR with the Merit-Based Incentive Payment System, or MIPS. MIPS means physicians are practicing better medicine to keep their patients healthier. Healthier people utilize less health care, which means a lower cost to the taxpayer.

Nearly 150,000 seniors live in my district. This bill gives them certainty that their doctor will see them. It provides seniors with better care.

H.R. 2 includes a 2-year extension for community health centers funding, which is very important to my constituents. This bill is pro-senior, pro-doctor, and pro-patient.

This is a historic moment, nearly 20 years in the making. We have a chance to make a huge difference for seniors. The benefits of repealing the SGR are clear. Support this bill.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentlewoman from Florida (Ms. CASTOR).

Ms. CASTOR of Florida. I thank the gentleman from New Jersey for yielding the time.

Mr. Speaker, I rise in support of this important, bipartisan, landmark bill.

Our parents and grandparents who rely on Medicare and the doctors that take care of them can breathe easier today because of this bill. Medicare will be stronger, and it will be more efficient. We are going to put ''modern'' into modern medicine by transitioning the Medicare health system into one that focuses on quality rather than quantity.

I would like to thank my colleagues on the Energy and Commerce Committee, Chairman UPTON and Ranking Member PALLONE, Mr. PITTS and Mr. GREEN, and Speaker BOEHNER and Minority Leader PELOSI for also adding into this important package new assurance for children across America, for our community health centers. The State Children's Health Insurance Program now gets a very significant boost, along with our health centers that take care of so many of our neighbors.

Thanks again to the professional staff, to the great public servants in the Obama administration.

I urge a ''yes'' vote on this important, landmark bill.

Mr. PITTS. Mr. Speaker, I am pleased to yield at this time 1 minute to the gentlelady from North Carolina (Mrs. ELLMERS), another valued member of the Health Subcommittee.

Mrs. ELLMERS of North Carolina. Mr. Speaker, I just want to extend my thanks to all of the members who have worked so hard, both on the Energy and Commerce Committee, but my Democratic colleagues across the aisle, those who we are working with in the Senate.

I just want to say to the American people, don't look now, but we are actually governing. And this is what the American people want to see.

I have a speech here to read, but I am actually going to go offline and tell you from my heart what this means for our seniors.

This is about certainty. This is about governing. This is about giving solutions to a problem. Yes, it comes with

a price tag. But when we continuously look at things from a one-dimensional perspective on something so important as health care—it is so multidimensional—we can't stop ourselves from moving forward.

Imagine a year from now where we will be when we are not trying to come up with another billion-dollar bandaid to continue the SGR failed formula, when we can actually be looking forward for solutions in health care, continuing our work on 21st century cures, and showing our seniors and every American family in this country how important it is in the work that we are doing.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from North Carolina (Mr. BUTTERFIELD).

Mr. BUTTERFIELD. I thank the gentleman from New Jersey (Mr. PALLONE).

Mr. Speaker, this is a good day for medical providers and for our seniors. This is also a good day for the House of Representatives. This is bipartisanship at its best.

With the passage of H.R. 2, seniors will no longer have to worry about losing their physicians. Providers will have the certainty to continue to serve their Medicare patients.

But this bill, Mr. Speaker, is about more than fixing Medicare. It also includes a 2-year extension of the CHIP program, which is children's health insurance, and funding for community health centers that is set to expire this fall. Both programs are vital to the low-income vulnerable and rural communities that I represent in North Carolina.

The CHIP program covers more than 8 million children across the country, including many in my State. It helps provide health coverage to children who are not eligible for Medicaid but cannot afford other insurance.

The community health center program funds 1,300 health centers across the country. Without this extension, the program would expire, and care for 7.4 million patients would be jeopardized.

Supporting this bill is about providing access to care for the most vulnerable Americans. I urge my colleagues in the House and the Senate to vote ''yes'' on H.R. 2.

Mr. PITTS. Mr. Speaker, I am very pleased at this time to yield 1 minute to the gentleman from Ohio (Mr. BOEHNER), our Speaker, who deserves a lot of credit in coming up with this bipartisan compromise.

Mr. BOEHNER. I thank my colleague from Pennsylvania for yielding.

Let me say a big thank you to Chairman UPTON, Chairman RYAN, Mr. PALLONE, Mr. LEVIN, and their staffs for all of the work that has gone into this product. Also, I want to thank Wendell Primus with Leader PELOSI's staff; Charlene MacDonald with Mr. HOYER's staff; and, of course, Charlotte Ivancic on my team, all who have worked together to create this product that we have today. Thanks to their hard work and the work of this House, we expect to end the so-called doc fix once and for all.

Many of you know that we have patched this problem 17 times over the last 11 years, and I decided about a year ago that I had had enough of it. In its place, we will deliver for the American people the first real entitlement reform in nearly two decades. I think this is good news for America's seniors, who will benefit from a more stable and reliable system for seeing their doctor.

□ 1045

It is good news for hard-working families who will benefit from a stronger Medicare program to help care for their elderly parents. It is good news for the taxpayers who, according to the CBO and a number of other fiscal experts, will save money now and well into the future. That means it is especially good news for our kids and grandkids, because today it is about a problem much bigger than any doc fix or any deadline. It is about beginning the process of solving our spending problem, and it is about strengthening and saving Medicare, which is at the heart of that problem.

Normally, we would be here to admit that we are just going to kick the can down the road one more time. But today, because of what we are doing here, we are going to save money 20, 30, and 40 years down the road. Not only that, we are strengthening Medicare's ability to fight fraud, waste, and abuse.

As was mentioned earlier, this bill also extends the Children's Health Insurance Program for another 2 years and extends the authorization for community health centers for another 2 years.

My colleagues, this is what we can accomplish when we are focused on finding common ground. But we can't become complacent. We know more serious entitlement reform is needed. It shouldn't take another two decades to do it, and, frankly, I don't think we have got that much time. But I am here today to urge all of our Members to begin that process, and the process begins by voting ''yes'' on H.R. 2 today.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentlewoman from Colorado (Ms. DEGETTE).

Ms. DEGETTE. Mr. Speaker, I rise today to support H.R. 2, the Medicare Access and CHIP Reauthorization Act.

As this legislation was under negotiation, several of our colleagues tried to add unnecessary language that would have expanded the Hyde amendment to embed this harmful policy into the Affordable Care Act and the Public Health Services Act. Thanks to the commitment of leaders for women's health care rights, we secured important changes to this language. Current appropriation policies concerning the use of funds at community health centers will not change, and when the funding in this bill for community health centers, the National Health Service Corps, and teaching health centers expires, so will the funding restrictions. Also, this language is freestanding, and it does not amend the Affordable Care Act or the Public Health Services Act.

Let me be clear. I oppose the Hyde amendment. It is backwards policy because it denies full reproductive coverage to poor women who need it the most of everybody in this society; but this bill does not restrict their access any further than current law, and the Pro-Choice Caucus will continue to fight for health parity in this country for all women.

In the meantime, we have a bill here that has real advances in finally fixing the physician reimbursement, extending the important Children's Health program, extending the special diabetes fund that helps so many Americans, and gives $7 billion to extend the important community health centers for the next 2 years.

Mr. Speaker, I am proud of the work we did in a bipartisan way. I want to thank the majority, and I want to thank my colleagues on my side of the aisle for working together and only showing, as the Speaker just said, what we can do when we really do the job that Congress is supposed to do. I urge support of this legislation.

Mr. PITTS. Mr. Speaker, I am pleased to yield 2 minutes to the gentleman from Texas (Mr. BURGESS), the prime sponsor of the legislation, who deserves a great deal of credit for where we are today.

Mr. BURGESS. Mr. Speaker, I want to thank the chairman of the Subcommittee on Health on Energy and Commerce. Mr. Speaker, I omitted one of the people that should have been thanked earlier in my remarks from the House Legislative Counsel, Michelle Vanek, who worked so hard on the language that is before us today.

Mr. Speaker, a year ago I came to this floor, we had a similar vote, and I talked about how important it was to send a positive message, because last year it was the key that would get us through the door. Well, guess what, Mr. Speaker. This year, not only will the key get us through the door; we are going to knock the darned door down.

We do need a strong vote today. We saw it evidenced on the rule. I urge all of my colleagues to get behind this legislation. It may not have been everything you want, it may not have been what you would have done if you had done it by yourself, but this is a collaborative body. This is the work of a collaborative body. Now we need to send it over to the world's greatest deliberative body. Let them deliberate for only a short period of time because of the thunderous approval that has come from the people's House.

Mr. Speaker, it is time to end the SGR. Let us never speak of this issue again.

Mr. PALLONE. Mr. Speaker, I yield 3 minutes to the gentleman from Maryland (Mr. HOYER), our Democratic whip.

Mr. HOYER. Mr. Speaker, as an aside, I was inclined to get up and ask that the gentleman's words be taken down. Of course, when we do that, we do it in a different context. With those words, we ought to all be happy today. Whether we are for or against, the Congress is working today as the American people would have the Congress work.

Speaker BOEHNER, Leader PELOSI, our extraordinary staffs on both sides of the aisle, and Members have come together and dealt with some difficult issues. As the gentleman, Dr. BURGESS indicated—and I have worked with him on SCHIP for a very, very long period of time as I recall—we are making progress. We are not where we all want to be, but we are making progress.

Mr. Speaker, I rise in support of this bill and thank the Democratic leader as well as Speaker BOEHNER, Ranking Members PALLONE and LEVIN, and the chairman of the committee, Mr. PITTS, and others for getting us to where we are today.

This bill will permanently replace the broken Medicare sustainable growth rate formula that, frankly, I have been working to get rid of for almost a decade, if not longer, which has created uncertainty and instability in the Medicare program for over a decade. I am pleased that the parties were able to come together and craft a bipartisan bill that will ensure seniors' access to their doctors and incentivize high-quality, high-value care.

I am also glad that this bill includes a robust reauthorization of the Children's Health Insurance Program, known as CHIP, which has been a bipartisan success story. This is an issue, Mr. Speaker, I worked hard on when I was majority leader, and I am glad that we are moving forward today in a bipartisan way that recognizes how important the CHIP program is for children and for families.

Another major component of this bipartisan compromise is the $7.2 billion in funding for community health centers. These centers serve some of our most needy citizens. These centers, in my home State of Maryland and throughout our country, provide essential health services for millions of underserved families. That is good for all of us.

This, of course, as I said, is not a perfect bill. No compromise is ever perfect from everybody's perspective. There are some parts I and other Democrats would have liked to see improved, just as there are some parts my colleagues on the other side of the aisle would change, but this compromise will provide much-needed relief and certainty to seniors, children, and families.

Mr. Speaker, I urge all of my colleagues to support this effort. It will be a good day for the Congress of the United States, and it will be a good day for America. I thank all of those whose leadership—Members and staff—who got us to this point for the work that they have done.

Mr PITT. Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield myself my 30 seconds remaining.

I want to recognize one person in particular, Ira Burney, a career civil servant who, for more than 30 years, has worked tirelessly on Medicare issues at CMS. There is not one Medicare bill in this time that he has not been a part of. His hard work and technical knowledge have been instrumental in supporting our work here in Congress.

So I want to thank Ira and all those on both sides of the aisle who worked so hard to make this day possible. This is an important and incredibly significant bill, and I urge my colleagues to support it.

I yield back the balance of my time.

Mr. PITTS. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. MCCARTHY), the distinguished majority leader.

Mr. MCCARTHY. I thank the gentleman, and I yield to my friend on the other side of the aisle, Mr. HOYER.

Mr. HOYER. I thank my friend, who has a magic minute that I dearly miss. I forgot to articulate, and I should have articulated, I want to congratulate FRED UPTON.

FRED UPTON is my friend. FRED UPTON is the chairman of the Energy and Commerce Committee. FRED UPTON is one of those Members in this House who represents this institution so well because he is committed to working in a bipartisan fashion. We find ourselves sometimes not able to do that. But I want to say thank you to Mr. UPTON from Michigan for his leadership and his commitment to making sure this institution works as the American people want it to work.

I thank my friend, the majority leader, for yielding.

Mr. MCCARTHY. Mr. Speaker, I thank the gentleman for his words, and I hope all that are watching today see that this is a pattern of what works inside Washington.

In Washington, Mr. Speaker, there is a common cycle: you have a problem, you kick the can down the road; you hit a cliff, then you rush to a short-term fix that doesn't actually fix the problem; then the cycle starts all over again.

This isn't a good way to govern. With this cycle, problems usually get worse, and a lot of times the short-term fixes get packed with add-ons that increase the size of government and cost people more and more. We have seen this with this doc fix again and again, 17 times over the last decade. Every single year I have served in this body, less than a decade, that has been the solution, to kick the can down the road. But today the House will vote on a bipartisan bill to end the cliff for good, stop the cycle, and, most importantly, provide stability to the Medicare program for the seniors and their doctors.

Mr. Speaker, this is a big moment for Congress, and I think we should all realize it. The bill before us today will, once and for all, repeal and replace the flawed Medicare physician payment system. It will move us away from volume-based care to care based on quality, value, and accountability.

Everyone knows that we need to reform programs like Medicare to save it for the future, but for so long, nothing has been done in this House—that is until today. Today marks the first step of what I hope will be many more to save our safety nets from collapse and to ensure it for a future generation. These reforms are permanent, they are bipartisan, and they lay the foundation for a Medicare that lasts.

We wouldn't be here to make all these big reforms without a lot of hard work.

First, I want to thank the Doctors Caucus. There are many times I was in a meeting with frustration wanting to find a solution, and the first place to find a solution is policy. They spent their time together to find that policy. Then it was: How are we going to pay for it and how are we going to move forward? That is where the leadership of chairmen come through in FRED UPTON and PAUL RYAN. They not only helped build with the Doctors Caucus, they led their own committees.

Today, when this vote is taking place, it is going to be different from others. People aren't going to sit and watch the sides to wonder whether it gets there and how close does it pass? People are going to watch how big the overall vote is going to be.

After this vote today, we will go back to our districts. We will go back to our districts, hopefully in a different thought and a different time, that yes, we can solve a problem; yes, we can pick a problem that has lasted over a decade, that every Congress before it has kicked it down the road, but no, we found common ground. We found the ability to come together to solve something that many believed we could not.

We hope the Senate will see the same value. Today is a good day, but today should not be the last day. We should look for the other problems—and there are many—and ways that we can solve them permanently like we will do today.

□ 1100

Mr. PITTS. Mr. Speaker, I am very pleased at this time to yield such time as he may consume to close to the gentleman from Michigan (Mr. UPTON), the chair of the Energy and Commerce, a master of bipartisan compromise who deserves a great deal of credit for being here today.

Mr. UPTON. Mr. Speaker, it couldn't be bipartisan if we didn't have good people on both sides of the aisle to get things done. I appreciate all the leadership on this side and this side to really get this to a finish point today.

Today, we do come together, we really do—Republicans and Democrats—to

finally, finally fix Medicare's broken payment system, protect seniors' access to care, and, yes, strengthen Medicare and extend the Children's Health Insurance Program.

For way too long, the so-called SGR has been an axe over Medicare physicians and the seniors that they care for. It has sparked crisis after crisis for nearly 20 years, forcing this Congress to pass some 17 temporary measures to undo its faulty math and protect seniors' access to their trusted doctors. Those 17 patches also served as a ready-made vehicle for bigger government. Today, we put a stop to that gravy train, leave the SGR in the past, and begin to put Medicare on the right track.

This bill is good for seniors and for doctors who treat them. We repeal the flawed SGR formula and replace it with a bipartisan, bicameral agreement on a new system that promotes innovation and higher quality care. It removes the hassle and worry that so many seniors and physicians face from the cycle of repeated patches.

We also take steps to strengthen Medicare for current and future seniors with structural reforms, which will not only provide cost savings today, but the CBO has confirmed those savings will grow over time. And the budget that we passed last night fully accounts for the cost of those permanent reforms.

This package also extends benefits for millions of low-income families and children by extending the Children's Health Insurance Program for 2 years. This program provides high-quality, affordable coverage for roughly 8 million children and pregnant women and has been an example of sound bipartisan success.

I want to thank the bill's sponsor, Dr. BURGESS, for his leadership on this issue from day one. He came to Congress to solve this problem and, today, we have a bill with his name on it to do just that.

I also commend the great subcommittee chair, JOE PITTS. Four years ago, we embarked together on this effort to end the SGR, and that hard work has brought us to this point.

I want to thank the full committee and the Health Subcommittee ranking members, Mr. PALLONE, my good friend, and Mr. GREEN, for working, again, across the aisle from day one. We wouldn't be standing here together if we hadn't started together.

Also, a big thanks to the folks at the House Legislative Counsel, CBO, and the committee staff: Clay Alspach, Robert Horne, Josh Trent, Paul Edattel, and Noelle Clemente.

Finally, I want to thank my friends on the Ways and Means Committee and our leadership on both sides, from JOHN BOEHNER and KEVIN MCCARTHY to NANCY PELOSI and STENY HOYER. We are, together, getting this done.

This is a long time coming. Most of us came to Congress to fight for our Nation's kids, seniors, and their families. Today's vote is a defining moment for this Congress and for Medicare. Those who vote ''no'' are not only voting against seniors but against the future of the critical safety net. That is why we all need to vote ''yes.''

Mr. PITTS. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The Chair recognizes the gentleman from Texas.

Mr. BRADY of Texas. Mr. Speaker, I yield myself such time as I may consume.

I rise on behalf of Chairman PAUL RYAN, chairman of the Ways and Means Committee, in support of H.R. 2, a bill led by Dr. MICHAEL BURGESS, and I am joined by many of our colleagues, both here in the House and throughout the country.

This bill is critical because of this problem. Imagine you are a senior. You desperately need to see a doctor, but you learn that there are no local doctors who can treat you because they simply can't afford to treat Medicare patients. Or they have been throughout the years faced each year with a 10, 20, 30 percent cut in their reimbursements and, as the sole practitioner or as a small business, have rethought their relationship with Medicare and are no longer, frankly, able to do that. That scenario has been played out across this country for far too long. If there is any group in America who needs to see doctors they know and who know them, it is our seniors.

This bill takes the first real permanent step to ensuring our seniors can see local doctors when they need to see them, and it takes the first real step in saving Medicare not just for these seniors, not just for the next generation, but for generations to come.

I commend the work that has been done by the leaders of the Ways and Means Committee; Chairman RYAN; Chairman FRED UPTON of the Energy and Commerce Committee; our physicians caucus, led by Dr. PHIL ROE and Dr. JOHN FLEMING; as well as those in this Chamber who have come together to make this historic step today.

So this is about helping our seniors. This is about taking those first reforms permanently to save Medicare. And it really is about ending a formula and a reimbursement that simply works against our seniors.

The flawed—they call it the ''sustainable growth rate,'' it dictates huge cuts to our physicians through Medicare. Congress had to intervene 17 times in recent years to stave off these cuts with short-term fixes. This flawed formula regularly threatens access to care for seniors and really distracts Congress from making real reforms that are needed.

The bipartisan agreement that we face today would repeal that SGR once and for all and replace it with a value-based system that provides certainty to our seniors and, really, finally reimburses doctors not on the number of procedures but on the quality they provide, and determined not by Washington but by our local physicians and practitioners themselves.

This reform alone, if that was the only thing this did, is significant. It begins to move its way from that flawed fee-for-service system. And it does in a way. The sole practitioner in rural Pennsylvania, as well as a doctor in a major institution in downtown Houston, can both practice to their highest capability and continue to practice until they decide to retire, not until Medicare or some flawed formula encourages them to retire early.

In addition, this bill has two important reforms, and I think critical reforms, to strengthen the Medicare Program and offset the costs of this measure. Similar reforms have been included in the House Republican budget for years. This is a bipartisan effort to work together with absolute dedication to make sure Medicare is around for our seniors.

First, it restricts first dollar coverage in Medigap plans. These are bipartisan recommendations experts believe will help reduce unnecessary costs and really strengthen programs over the years.

Second, the agreement includes increased means testing for premiums in Medicare parts B and D, our doctors, and our medicines, with the wealthiest seniors paying higher premiums. And then there are savings from a broad range of other healthcare providers.

I want to make clear, this bipartisan reform alone will not save Medicare, but it takes us in the right direction for the very important first step, and the savings from this will grow over the long term.

The alternative we refuse to pass is yet another cycle of short-term fixes, leaving behind bipartisan structural reforms to Medicare and delaying the opportunity to actually save this program for our seniors.

So, today, we end the SGR, we begin the important reform, and we stand up for seniors who need to see doctors.

With that, Mr. Speaker, I reserve the balance of my time.

Mr. LEVIN. Mr. Speaker, I yield myself such time as I may consume.

Well, this is, indeed, a rare event. It was an event really waiting to happen because, a year ago, our committee, Ways and Means, chaired by Dave Camp, alongside the Energy and Commerce and Senate Finance Committees, reached a bipartisan, bicameral agreement to move the physician reimbursement system to one based more on quality, not quantity. This helped pave the way for the package in front of us today, negotiated with the key help of the Speaker and our Leader.

The SGR has been hanging over our heads for more than a decade. We have paid close to $170 billion in short-term patches. With each patch, it becomes harder to find offsets, putting seniors in our healthcare system increasingly at risk. This is being done—and I emphasize that—while maintaining the

basic structure of Medicare. Talk otherwise is mistaken.

Our approach to paying for this reform is a reasonable one. We are paying for additional benefits, but not to dig out of the hole created by the flawed budget formula.

This package includes a number of improvements across the healthcare landscape. It fully funds a 2-year extension of CHIP at the increased level of funding that we included in the Affordable Care Act. It permanently extends the qualifying individual program that pays Medicare premiums for low-income seniors. It permanently extends the transitional Medicare Medical Assistance Program, which helps Medicaid beneficiaries transitioning back to work to keep their insurance. It secures $7.2 billion in funding for community health centers, ensuring that 7 million Americans who depend on these establishments for care can get it. And it makes progress in fighting fraud and abuse in Medicare.

What I would like to do—it will take a little more time—is to thank the staff. We don't do that enough. So I want to thank Wendell Primus, Charlene MacDonald, Clay Alspach, and Matt Hoffmann. And, of course, the Ways and Means Committee health staff, particularly Amy Hall and Erin Richardson.

And we need to thank the excellent drafters from the House Legislative Counsel Office, led by Ed Grossman, who I think is here today, along with the Centers for Medicare and Medicaid Services Office of Legislation, particularly Ira Burney, who is known for his deep knowledge of Medicare and who helped put the package together in a technically sound manner. And the CBO health team led by Tom Bradley, who worked expeditiously to meet our timetable.

And I want to close my remarks by paying tribute to a Member who is not with us today, who worked for years on these issues, John Dingell of Michigan, for the years he put in protecting and strengthening Medicare, Medicaid, and CHIP, including trying to fix SGR.

We are fixing SGR today, and we are strengthening Medicare, Medicaid, and CHIP. This is a day where there was common ground, and today we stand on it.

I reserve the balance of my time.

Mr. BRADY of Texas. Mr. Speaker, I yield 2 minutes to the gentleman from Pennsylvania (Mr. KELLY), a successful small business person who has provided health care to his more than 100 employees for years, a key leader of the Ways and Means Committee.

Mr. KELLY of Pennsylvania. Mr. Speaker, I thank the gentleman.

We rise today. Really, this is not so much a doc fix as a senior fix. And while our lives are usually defined by wins and losses, I would think that really in our lives we remember the losses far more than we remember the wins. And the reason I say that is, I have been there for the birth of my four children, and I have celebrated the birth of our 10 grandchildren. Those are great moments. But I have also sat by the bedside of my mother, my sister, and my father as they lay dying and were transitioning.

□ 1115

Those losses are things that you can never truly regain. Those are the times when, if you just had 1 minute left with those folks, wouldn't you love to have that? Wouldn't you love to be there with them to give them peace of mind? This bill gives them peace of mind, Mr. Speaker. That is what this bill does. This is a senior fix.

I will tell you, when I have watched people as they have passed—both friends and family—what they have wanted at their bedsides at that time is to have their faith with them so that they know they are surrounded by their God, so that they know that where they are going is best, and so that they know that somehow their futures are going to be okay.

They also want the comfort of knowing that their families are there with them, helping them to get through the toughest parts of their lives, when they are at their most vulnerable, whenever they need the most help.

Lastly, they want their doctors. They want to know that that person who has guided them through the last several months and through their lives—the person they have always gone to for their health care—is going to be there and is not going to be taken away because of some government program that didn't work.

I would say, as we sit in America's House, whether we are Republicans or Democrats—and our gallery is filled with people—we are people who are representing people and the best interests of people.

This piece of legislation today is truly a senior fix, but it is a fix for the most vulnerable. I can think of nothing that we could do that is more important than giving peace of mind to those who have given so much to us as families, as States, and as a country. This is a brilliant piece of legislation.

While it may not satisfy all, it serves the needs of so many.

Mr. LEVIN. Mr. Speaker, I yield 3 minutes to the gentleman from Washington (Mr. MCDERMOTT), who is the ranking member on the Health Subcommittee.

(Mr. MCDERMOTT asked and was given permission to revise and extend his remarks.)

Mr. MCDERMOTT. Mr. Speaker, today is, in a sense, an historic event. We are finally putting to rest a problem that has festered around here for as long as I have been here.

Every year, as the deadline approached, providers faced draconian cuts, and Congress passed an eleventh hour patch that delayed the implementation of SGR. Doctors, patients, Congress—nobody—liked it. Nevertheless, 17 times, we have made temporary fixes. We have spent $174 billion in inadequate ways in dealing with the real problem that SGR was all about, which is cost control.

This is a first step today. We can celebrate, but we have to go on because cost control is still a question, and we have replaced SGR with a system that we hope will make Medicare pay for value rather than for volume. That is not an issue that is for sure. We know that we are trying it.

I thought of Franklin Delano Roosevelt, who once said:

> I will try something. If it doesn't work, I will stop it and try something else.

That is really where we are today, looking at the future of cost control in health care.

The most important thing today, though, is that we have gotten back to regular order. The Republicans put this in 16 years ago. Some of us voted ''no'' because we knew it wouldn't work, but we had all of our 17 years. Now, we come together to fix it together, and we have to fix things together in this House. Compromise is the essence of what we have here.

For my friends on the other side, just so you understand, I have already had a phone call from a group in Washington State who told me they are going to take me off the board if I vote for this.

It isn't as though this is a nice thing for one side or the other side. It is a compromise, where some people get what they want and where some people don't get what they want. Some people think it is not enough, and some think it is too much.

That is the essence of compromise, and that is how the Congress has to work. It is what is going to have to work with the ACA, the Affordable Care Act. It is going to have to work on transportation. It is going to have to work on a whole series of issues if we, as a Congress, are going to function on behalf of the American people.

This is a great day. This ought to be a unanimous vote today. When you look at all of the things that are in it and at all of the things we have dealt with, it ought to be unanimous. My view is that, when you reach a compromise, that is the kind of thing you can expect because nobody in this House ever gets all he wants. Nobody has the right to say: it is my way or the highway.

When we do that, we damage the American people. We have been damaging the healthcare system with these patches, spending all of that money, and not getting what we want. We hope this is the start of a better day for cost control in health care. Everyone should vote for this.

Mr. BRADY of Texas. Mr. Speaker, I am proud to yield 2 minutes to the gentleman from Pennsylvania (Mr. MEEHAN), who is a champion in health care and whose district has a large number of seniors.

Mr. MEEHAN. Mr. Speaker, I rise today in strong support of the Medicare Access and CHIP Reauthorization Act of 2015.

This is the product of several years of sustained bipartisan work, and, today, we can finish the job. This is a critically important piece of legislation for seniors because it is going to strengthen and preserve the Medicare Program, and it is going to put an end to the perennial drills that threaten seniors' access to high-quality care, the care that they deserve.

H.R. 2 is a result of bipartisan compromise. I am sure my friends on both sides of the aisle can agree, as my good friend from Oregon identified, that it isn't perfect, but I am pleased that they will also extend funding for the Children's Health Insurance Program. Just like our seniors, we need to make sure that our kids have access to high-quality, affordable care. We also continue to support community health centers, which provide quality care for those of lesser means.

Since 2002, Congress has passed 17 patches to avert the SGR's draconian cuts. These patches avoid crisis, but they don't do anything to preserve or improve the Medicare Program for current and future seniors, so I am delighted that, together, we can finally forge a lasting solution.

This isn't just good for seniors' care and for our healthcare workforce; it is a sign that partisan differences in Washington can be bridged to address our biggest challenges. I urge my colleagues to support this legislation, and I hope the Senate will send it to the President and get it signed quickly.

Mr. LEVIN. Mr. Speaker, how much time is there, please, on both sides?

The SPEAKER pro tempore. The gentleman from Michigan has 8 minutes remaining, and the gentleman from Texas has 7 minutes remaining.

Mr. LEVIN. Mr. Speaker, it is now my pleasure to yield 2 minutes to the gentleman from Oregon (Mr. BLUMENAUER), a distinguished member of our committee.

Mr. BLUMENAUER. I appreciate the gentleman's courtesy, as I appreciate his leadership on this.

Mr. Speaker, I have sat on the floor for the entire debate—of both the Commerce and Ways and Means Committees—and it is really exciting. I was one of those people who didn't vote for the balanced budget agreement back in the day, but I have been frustrated by this as much as anybody. I had legislation that would just simply reset the baseline, but, actually, this is better.

It is better because we have had Ways and Means, Commerce, and Finance Committees come together for several years and develop a reform that will strengthen opportunities for better payment. It is better because we have seen the minority leader and the Speaker of the House come together to empower the committees to do their job.

I was struck by the words of Majority Leader McCarthy when he said this was a good day, and he thinks that this will not be the last such day. I sincerely hope that that is the case, that it signals opportunities for us all to go forward.

I like the fact that we have added things in here like the SCHIP. We have even gotten Secure Rural Schools, funding extended which makes a big difference for people in the West, especially Oregon.

I am hopeful that we can step forward. We have got another cliff that is facing us in 2 months: the transportation cliff. People are talking about 17 SGR fixes here when we have had 23 short term extensions for the transportation system.

I would hope that we could take the same spirit of cooperation and bipartisanship and listen to people in the outside world—organized labor, the AFL–CIO, the U.S. chamber, contractors, local government, environmentalists—who are all speaking with one voice: Congress, get your act together; give us funding to be able to fund the transportation bill for the first time in years and rebuild and renew America, to put people to work—and to show the same sort of bipartisan cooperation that I find really invigorating today.

I hope the next thing we do is have the Ways and Means Committee, the committee of jurisdiction, step forward to solve the transportation problem. It is even easier than the SGR.

Mr. BRADY of Texas. Mr. Speaker, I am proud to yield 1½ minutes to the gentlewoman from Tennessee (Mrs. BLACK), who has spent more than 40 years in health care as a nurse and as a small-business owner.

She is a member of the Doctors Caucus here and is a key leader in health care on the Ways and Means Committee.

Mrs. BLACK. I thank my colleague, who is someone who has worked tirelessly on this issue and who is a leader on our healthcare committee.

Mr. Speaker, I rise in strong support of the Medicare Access and CHIP Reauthorization Act of 2015.

This bipartisan legislation offers a permanent solution to strengthen the Medicare Program that our Nation's seniors and their doctors rely on. It would repeal the flawed SGR formula that dictates draconian cuts to Medicare reimbursements, and it would do so in a fiscally responsible way that would provide important offset savings.

Since 2003, Congress has spent $170 billion on short-term fixes that has staved off these cuts without making the real reforms that are needed, and this cycle has done nothing to address the real problems of our entitlement spending.

I have been a nurse for more than 40 years, as has been said, and I know that you can't put a bandaid on a problem that needs to be corrected by surgery. The problems impacted and affected by these looming cuts were my patients and my colleagues.

I urge this body to end the SGR crisis once and for all. Adopt these structural reforms, and help us move forward together to strengthen Medicare for today's seniors and tomorrow's retirees.

Mr. LEVIN. Mr. Speaker, I yield 2 minutes to the gentleman from New Jersey (Mr. PASCRELL), a very vocal member of our committee.

Mr. PASCRELL. I have got to say this to Chairman BRADY and to our leader, Mr. LEVIN: you guys did a great job in keeping us together, and I think the words that I will take away are what Dr. BURGESS said about this being a collaborative effort.

Mr. Speaker, if someone came down from Mars today into this Chamber, he would be shocked by the camaraderie. This is great. This is a good feeling. You have got to admit it is a good feeling. I know it is before Palm Sunday, but I have got a good feeling today, on Thursday.

This effort, I think, establishes a very good precedent for revitalizing the integrity of this Congress, of this institution. We here, Mr. BRADY and Mr. LEVIN, got out of our echo chambers. We love to hear ourselves. You know that. It is part of the DNA of being a Congressperson.

We got out of those echo chambers, and we actually listened to each other. That is shocking. If we can rise above our own attempts to be ideologues, we can accomplish a hell of a lot here for the people of the United States. They deserve no less.

The repeal and the replacement of SGR ends the constant looming of deep payment cuts to Medicare physicians, which, as we have heard, jeopardizes the participation in the program and jeopardizes seniors' access to their doctors. As a result of this law, our Medicare payment system will finally be rooted in the quality of services provided as opposed to the quantity, results rather than fee for service.

I must say, Mr. Speaker, that I urge my colleagues to vote for this legislation. It is good for America.

Mr. BRADY of Texas. Mr. Speaker, I am proud to yield 1 minute to the gentleman from Florida (Mr. CURBELO), a new Member of Congress who is passionate about health care, reforming Medicare, and helping seniors.

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Mr. CURBELO of Florida. Mr. Speaker, I rise today in strong support of H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015, and I would like to thank the Committee on Ways and Means and Committee on Energy and Commerce for taking bold leadership on such a critical issue.

Sustainable growth rate is a budget cap on physician services passed into law in 1997 to control spending. Unfortunately, the SGR formula is fundamentally broken. Since 2003, Congress has spent nearly $150 billion in 17 separate short-term patches to prevent significant Medicare reimbursement rate cuts. This uncertainty is detrimental to providing our seniors and our doctors with the confidence that they deserve.

This bill before us today repeals the outdated SGR formula and replaces it with a new permanent system that rewards quality and value and guarantees stability to Medicare beneficiaries and the physicians providing their treatment.

Most of all, Mr. Speaker, I want to thank our leaders for allowing us to have this special moment. Today, the American people have the Congress that they deserve, a Congress that is focused on advancing an agenda that can make the American people proud. Let us continue walking down this path together.

Mr. LEVIN. I yield 2 minutes to the gentleman from Illinois (Mr. DANNY K. DAVIS), another active member of our committee.

Mr. DANNY K. DAVIS of Illinois. Mr. Speaker, it takes a lot of time, energy, effort, hard work, and study to become a physician. I think they ought to be adequately compensated for the services they provide, especially when they serve the most needy health population in our country—our senior citizens.

We call this the doctor fix, but it is really not about the doctor fix. It is about fixing health care. It is about CHIP. It is about community health centers that serve more than 23 million low- and moderate-income citizens each and every year. It is about the National Health Service Corps training physicians. It is about the home visiting program.

I represent a district that has 24 hospitals, four outstanding medical schools, and so we train and educate many doctors, nurses, and other health personnel.

This is not just a good day for the doctors; it is a good day for health care, and it is a good day for America.

Mr. Speaker, H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015 is a bill that determines how doctors get adequate pay for providing medical services to Medicare recipients. For the past 12 years, the Medicare sustainable growth rate (SGR) formula has impeded stability in the Medicare program for providers and beneficiaries. Seventeen times Congress have done short term fixes, known as patches, that range from 3 to 12 months. Physicians should and deserve equitable reimbursement and not a lower reimbursement rate for the services they provide to our seniors. This is one of the leading reasons why physicians are leaving their practice or not accepting Medicare patients. We should repeal SGR and establish a legislative long-term fix that offers payment stability for our doctors. H.R. 2 will do just that and allow doctors to develop long-term strategic planning for their practice and time to invest in electronic health information technology and other medical systems to improve access and quality care for their patients.

Now is the time to capitalize on the lower offset now projected for the permanent repeal of the SGR formula otherwise failure to do so may cause problems for many providers to see Medicare patients. Ten thousand new enrollees enter Medicare each day. Access to physicians will suffer for the Medicare population as the gap between payments and practice costs continue to grow.

H.R. 2 fully fund the Children's Health Insurance Program (CHIP) for two years. CHIP is a partnership between the federal government and the States to provide healthcare coverage for over eight million children. Also, this legislation extends funding for two years to Community Health Centers to avoid draconian cuts to their services and operations in their communities. Community health centers play a critical role in the delivery of care to our most financially and medically vulnerable populations, and thus play an instrumental role in efforts to achieve health equity. Health centers serve one in seven Medicaid beneficiaries, one in seven uninsured, and one in three individuals living below poverty. African Americans, Asians/Hawaiians/Pacific Islanders, American Indians/Alaskan Natives, and persons with multi-racial and ethnic backgrounds account for 36 percent of all health center patients. Approximately 34 percent of health center patients are Hispanic/Latino, and health centers serve one in four racial and ethnic minorities living in poverty.

Community health centers are a local solution to the delivery of primary care—which is precisely how care works best—and services that are tailored to meet local needs, specific to each community. Health centers save the health care system money by keeping patients out of costlier health care settings, coordinating care amongst providers of different health disciplines, and effectively managing chronic conditions. Recent independent research shows that health centers currently save the health care system $24 billion annually in reduced emergency, hospital, and specialty care costs, including an estimated $6 billion annually in combined state and federal Medicaid savings. Despite serving traditionally at-risk populations, community health centers meet or exceed national practice standards for chronic condition treatment and ensure that their patients receive more recommended screening and health promotion services than patients of other providers. Health centers also have a substantial and positive economic impact on their communities. In 2009 alone, health centers across the country generated $20 billion in total economic benefit and produced 189,158 jobs in the nation's most economically challenged neighborhoods.

H.R. 2 includes the MIECHV home visiting program, which I worked in a bipartisan and bicameral way in Congress to establish a national program that serves approximately 115,000 parents and children. Under this legislation this program will be extended to improve child health, child development, and readiness to learn.

Mr. Speaker, I rise in full support of H.R. 2 and encourage all my colleagues to vote for this bill.

Mr. BRADY of Texas. Mr. Speaker, I yield myself 30 seconds.

I include in the RECORD a list of over 100 healthcare organizations throughout America—and growing—who support the passage of this legislation today. I would like to point out that these represent physicians and healthcare providers who truly want to treat our seniors, to see them when they need to see them, but can't today because of the way Medicare pays them.

So we start with a fresh start, and I enter into the RECORD this list.

Alliance for Academic Internal Medicine (AAIM); AMDA The Society for Post-Acute and Long-Term Care Medicine American Academy of Allergy, Asthma, and Immunology (AAAAI); American Academy of Dermatology Association; American Academy of Family Physicians; American Academy of Neurology (AAN); American Academy of Ophthalmology; American Academy of Pediatrics; American Action Forum; American Association for the Study of Liver Diseases (AASLD); American Association of Clinical Endocrinologists (AACE); American Association of Neurological Surgeons/Congress of Neurological Surgeons; American Association of Nurse Anesthetists; American Association of Nurse Practitioners (AANP); American Association of Orthopedic Surgeons; American College of Allergy, Asthma and Immunology (ACAAI); American College of Cardiology (ACC); American College of Chest Physicians (CHEST); American College of Physicians (ACP); American College of Radiology.

American College of Rheumatology (ACR); American College of Surgeons; American Congress of Obstetricians and Gynecologists; American Gastroenterological Association (AGA); American Geriatrics Society (AGS); American Health Care Association; American Hospital Association; American Medical Association; American Medical Society for Sports Medicine (AMSSM); American Osteopathic Association (AOA); American Society for Blood and Marrow Transplantation (ASBMT); American Society for Gastrointestinal Endoscopy (ASGE); American Society for Radiation. Oncology (ASTRO); American Society of Clinical Oncology; American Society of Hematology (ASH); American Society of Nephrology (ASN); American Thoracic Society (ATS); Americans for Tax Reform; Association of Departments of Family Medicine; Association of Family Medicine Residency Directors.

Aurora Health Care; Billings Clinic; Bipartisan Policy Center; California Medical Association; Center for Law and Social Policy (CLASP); College of American Pathologists; Digestive Health Physicians Association; Endocrine Society (ES); Essentia Health; Federation of American Hospitals; Grace Marie Turner for the Galen Institute; Greater New York Hospital Association; Gundersen Health System; HealthCare Association of New York State; Healthcare Leadership Council; Healthcare Quality Coalition; HealthPartners; HealthSouth; Hospital Sisters Health System; Infectious Diseases Society of America (IDSA).

Iowa Medical Society; Let Freedom Ring; Louisiana Rural Health Association; LUGPA; March of Dimes; Marshfield Clinic Health System; Mayo Clinic; McFarland Clinic PC; Medical Group Management Association; Mercy Health; Military Officers Association of America (MOAA); Minnesota Hospital Association; Minnesota Medical Association; National Association of Community Health Centers; National Association of Spine Specialists; National Association of Urban Hospitals; National Coalition on Health Care; National Retail Federation; North American Primary Care Research Group; Novo Nordisk.

Oregon Association of Hospitals and Health Systems; PhRMA; Premier Inc.; Renal Physicians Association; Rural Wisconsin Health Cooperative; Society for Adolescent Health and Medicine (SAHM); Society of Critical Care Medicine (SCCM); Society of General Internal Medicine (SGIM); Society of Teachers of Family Medicine; Tennessee Medical Association; Texas Medical Association; The 60 Plus Association; The American College of Gastroenterology; The Hospital & Healthsystem Association of Pennsylvania; The Iowa Clinic; The Society

of Interventional Radiology; ThedaCare; Wisconsin Collaborative for Healthcare Quality; Wisconsin Health and Educational Facilities Authority; Wisconsin Hospital Association; Wisconsin Medical Society.

Mr. BRADY of Texas. Mr. Speaker, I reserve the balance of my time.

Mr. LEVIN. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Texas (Ms. JACKSON LEE).

Ms. JACKSON LEE. Mr. Speaker, I thank the distinguished gentleman from Michigan and my friend from Texas, and what a celebration of Members coming together, Republicans and Democrats.

Mr. Speaker, I stand on this floor to ensure and insist that I am here to protect seniors and to ensure that the vote taken today does not undermine the protection of Medicaid and Medicare, in particular Medicare for our seniors, and that any vote does not in any way hinder those and provide a burden for those who cannot pay.

This provides a pathway for providing for our medical providers with the SGR fix; it provides seniors with quality healthcare services so they can go to the doctor they want; and, yes, it provides quality funding for our children and for our low-income families.

It supports our federally qualified health clinics, and coming from the city of Houston with the Texas Medical Center, there are a lot of doctors. Those doctors serve the poor and they serve seniors, and I want to make sure they are able to do so. The CHIP program will be protected that has been a vital program to provide for those families for our children to be healthy.

Let me agree with my colleague, brother PASCRELL, this is good for America. I am delighted to support this, and we are going to help physician-owned hospitals and look forward to a better day.

Mr. Speaker, I rise in support of H.R. 2, the ''Medicare Access and CHIP Reauthorization Act of 2015,'' and the underlying bill.

H.R. 2 repeals and replaces the Medicare Physician Payment System and incentivizes quality care for seniors, children and low income-families.

I thank Chairman RYAN and Ranking Member LEVIN for their work in shepherding this legislation, which enjoys bipartisan support to the floor.

I support the bill before us because it protects our seniors, our children, low-income families, and equitably compensates physicians who provide critically needed health services.

This bipartisan legislation represents a significant achievement because it reforms Medicare's payment system and maintains critical funding for health care for millions of seniors, low-income children, and families.

Compensating our medical providers adequately to enable them to continue providing much needed services to our seniors is a moral imperative.

Assuring that our seniors receive quality health services is a moral imperative.

Providing critical healthcare funding for children and low income families is also a moral imperative.

Physicians from my congressional district in Texas, and others across the country, serve and provide remarkable healthcare to our seniors, children, and low income families.

The 70,000 seniors in my congressional district are entitled to the security that comes from knowing that healthcare will be available to them when they need it the most.

The 4.4 million low income families and children in the state of Texas and the 130,000 children in Harris County will benefit from this bill because it provides the resources needed to improve their quality of health.

It is important that physicians who are willing to serve our seniors, children, and low income families not have to go broke doing so.

Mr. Speaker, let me briefly list several of the more important aspects of this bill which I wholeheartedly support:

For our seniors, the bill repeals the sustainable growth rate (also known as SGR) formula and phases in a value based payment system for physicians serving Medicare patients for the quality of care they provide.

For our seniors, children and low-income families, the new payment incentives in the bill encourage physicians to move towards alternative payment models such as bundled payment and shared savings which foster alignment of high-quality and cost effective healthcare.

This bill extends the Children's Health Insurance Program, or CHIP, for two years.

Over 928,000 children are in CHIP in Texas, and 130,000 in Harris County, will benefit from this bill.

For our children, ''clean'' extensions in the bill maintain policies and funding that does not include detrimental policies or cuts.

This funding supports evidence-based programs that have been proven to reduce health care costs, improve school readiness, and increase family self-sufficiency and economic security.

This bill extends the Maternal, Infant, and Early Childhood Home Visiting Program for two years.

This bill extends funding for 1,300 federally funded community health centers located in all 50 states, the District of Columbia, and six U.S. territories, distributed evenly between urban and rural areas, that serve 28 million patients.

A third of those patients are children, and 93 percent of patients served have incomes below 200 percent of the federal poverty line.

The vast majority of the 90 million patient visits to community health centers were for primary medical care.

Without the funding, 7.4 million low-income patients—including 4.3 million women provided by this bill would lose access to health care.

This bill extends the Qualifying Individual Program—which subsidizes Medicare premiums for low-income beneficiaries—permanently.

This bill permanently corrects Medicare payments to physicians an provides much-needed certainty and stability to the Medicare program.

Importantly, the bill provides financial incentives to reinforce the country's path toward a health care system that rewards value and quality of care.

Mr. Speaker, this bipartisan legislation is a step in the right direction in Medicare payment reform and ensures continued funding that improves the health and welfare of millions of seniors, children, and families.

H.R. 2 is important because it reforms our flawed Medicare physician payment system; incentivizes quality and value for our seniors; and extends coverage for our children and low income families.

For all these reasons, I strongly support this bill and urge my colleagues to likewise.

Mr. BRADY of Texas. Mr. Speaker, I know Mr. LEVIN has additional speakers, so I will reserve the balance of my time.

Mr. LEVIN. I yield myself the balance of my time.

Mr. Speaker, this is an important moment. As I look back, it has been decade after decade of a struggle for health care for all Americans, a real struggle.

Today, we have legislation that covers kids from infancy through seniors, for seniors throughout their years. That is the importance, really, of these provisions. I simply want to express, I think, the feeling of so many of us on this side. So we have this moment of coming together, and I hope in the days ahead that these notes of harmony will not be disturbed by notes of dissonance. We owe more, and all the bodies, all the institutions owe it to the people of this country to continue on this path so what should be a right is a reality.

I don't think anybody in this institution can imagine going to bed any night worried about having health care, and the same for their families, their kids, and their grandchildren. I hope we will take these few minutes when we come together and reassert the importance in this country of joining together so that everybody from birth until their last days has the ability to have what is so precious—the ability to have access to health care. I hope that is the significance of this vote. I hope, as a result, it will be a very strong vote, and I think it is a vote for health care for every American.

I yield back the balance of my time.

Mr. BRADY of Texas. I yield myself the balance of my time to close.

Mr. Speaker, there is nothing wrong with being passionate about your ideas and principles, and nowhere is that more evident than in health care. When you can find, though, common ground on those principles that help our seniors, encourage our doctors to treat them, and make the first reforms to really save Medicare for the long term, we ought to do that. That is what this bill does.

But it just isn't a common ground as far as our lawmakers. We have dedicated staff who came together to work out the tough issues for us as well. On behalf of the Committee on Ways and Means Chairman PAUL RYAN and myself, I would like to thank our staff on the Ways and Means Subcommittee on Health—Matt Hoffmann, Brett Baker, Amy Hall, and Erin Richardson—for their tremendous work.

The Speaker and former Speaker PELOSI also led the effort to find this

common ground, and for Speaker BOEHNER, Charlotte Ivancic, and for Leader PELOSI, Wendell Primus, we thank you, as well as legislative counsel; and for the Congressional Budget Office, Tom Bradley and Holly Harvey contributed greatly to this day.

The other day, my neighbor, who has just retired from Continental, now United, walked over to my front porch and told me that after years of seeing his local doctor, his local doctor can't see him anymore because he can't afford to treat Medicare patients.

The other day—it was a tough winter for illnesses—I had an ear infection, and my local doctor I have known since he started his practice snuck me in at 6 at night. His staff had been there since 8 in the morning working and just looked frazzled. He just said, look, he doesn't drive a fancy car, doesn't live in a fancy home; he doesn't have a fancy office; he just wants to help treat patients. But this formula just makes it harder and harder for him. My main physician, who is 66, told me the other day that he would like to practice for 5 more years. He said: I think probably just 1 more year. He said: I can't handle the way Medicare pays today.

Look, we can't allow that to continue. Today, a simple question on this bill: Will you stand with our seniors, who need to see a local doctor and a doctor they know? Will you stand with our doctors, who want to treat our seniors, who don't want to retire early or sell out to larger institutions? Will you take the first real step to save Medicare for the long term? That is the question we face today.

On behalf of Chairman RYAN and those who have come together on this bill, I urge a ''yes'' vote on this measure.

Mr. Speaker, I yield back the balance of my time.

Mr. RYAN of Wisconsin. Mr. Speaker, here's what it all comes down to: This is a step toward patient-centered health care.

And what that means is, we're starting to focus on what's best for patients.

Medicare is supposed to help seniors get the best health care possible.

And the way to do that is to reward what works.

Reward the doctors who help you recover faster and live longer.

Reward the doctors who put seniors and their health first.

That's what it means to have a patient-centered system. That's how you strengthen Medicare.

And that's what this bill does. This bill changes how Medicare pays doctors.

Right now, you get paid for every single treatment you perform—no matter how effective you are.

So what we say to doctors is, ''From now on, we're going to reward quality work. Do a good job, make people better, keep them out of the hospital, and you'll get paid more.''

I think we all can agree that's better than just paying for the amount of care.

And we can all agree that's better than one more year of a manufactured crisis.

Now I want to add that we make a couple of other good reforms in this bill.

These reforms will save money. And those savings will build up over time.

We ask the wealthy to contribute more to their care.

We discourage unnecessary doctor visits with some insurance reforms.

And we tell Medicare to share data with experts to help providers figure out what works.

You all know I think we have a long way to go to save Medicare.

I think this is just a start.

But this is a firm step in the right direction.

It's a firm step toward a patient-centered system.

And I ask all my colleagues to support it.

COMMITTEE ON WAYS AND MEANS,
HOUSE OF REPRESENTATIVES,
Washington, DC, March 20, 2015.

Hon. FRED UPTON,
Chairman, Committee on Energy and Commerce, Rayburn House Office Building, Washington, DC.

DEAR CHAIRMAN UPTON: Thank you for your letter regarding H.R. 1021, Protecting the Integrity of Medicare Act of 2015, which was ordered reported by the Committee on Ways and Means on February 26, 2015. I appreciate your decision to facilitate prompt consideration of the bill by the full House. I understand that by foregoing a mark-up of the bill, the Committee on Energy and Commerce is not waiving its interest in the provisions within its jurisdiction.

Per your request, I will include a copy of our exchange of letters with respect to H.R. 1021 in the Congressional Record during House consideration of this bill. We appreciate your cooperation and look forward to working with you as this bill moves through the Congress.

Sincerely,

PAUL RYAN,
Chairman.

Ms. FRANKEL of Florida. Mr. Speaker, I rise today to express my disappointment that Hyde Amendment language was included in H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015.

The Hyde Amendment, which prohibits federal funding for abortion, has prevented women from accessing needed reproductive health care for decades. While the Hyde Amendment remains in law through the yearly appropriations process, every attempt to insert Hyde Amendment language into other legislation damages efforts to protect women's health.

It is unfortunate that today's historic bipartisan deal—which will strengthen Medicare for millions of Floridians—was used as a vehicle to chip away at women's access to reproductive health care. Every woman deserves the right to make her own personal health decisions.

Mr. FARR. Mr. Speaker, I rise today to thank our leaders for working so tirelessly to find a compromise to fix the SGR. For too many years this arbitrary budget device has worked to upend Medicare doctors and patients alike, creating turmoil when what was needed was common sense. Thankfully, today common sense wins out.

But I have to say as well that I am disappointed that the bill includes unnecessary language on restricting women's reproductive rights. The inclusion of a statutory reference to the Hyde amendment is bothersome in the least and very possibly a dangerous precedent-setting salvo by anti-choice opponents to codify the Hyde language.

Mr. Speaker, I don't understand why Hyde had to be referenced at all in this bill. Everyone already knows that community health centers are already subject to Hyde restrictions. Including it in this SGR bill is redundant. Unfortunately, it is all too typical of this Tea Party-infused Congress to sow discord rather than accommodation. Adding the Hyde language to the bill only causes heartburn in a bill that could much more easily have satisfied our hunger for bipartisanship.

Ms. BONAMICI. Mr. Speaker, I rise today in support of H.R. 2, the Medicare Access and CHIP Reauthorization Act. This legislation is a long overdue remedy to the flawed Medicare physician payment formula known as the Sustainable Growth Rate, or SGR. I look forward to putting an end to the temporary patches that Congress has repeatedly passed in place of a permanent fix.

Replacing the SGR and bringing predictability to Medicare will encourage more providers to enter and remain in the program, which in turn will improve health care access and affordability for seniors. Additionally, H.R. 2 marks an important shift from fee-for-service payments to a system that rewards quality outcomes.

This bill also includes several important reauthorizations to crucial programs, including the Children's Health Insurance Program, the Qualifying Individual program, and the Maternal, Infant, and Early Childhood Home Visiting Program. Although I would have supported a longer authorization of CHIP, which would bring more certainty to our states and the children and families they serve through the program, I hope we can work together during the next two years to develop a strong authorization before it expires in two years.

I am also very pleased that this legislation includes an extension of the Secure Rural Schools and Community Self-Determination Act. Hundreds of jurisdictions across the country—including timber-dependent counties all across Oregon—rely on this essential funding for their schools, government services, and law enforcement.

Lastly, H.R. 2 provides continued authorization for Community Health Centers, which provide important services in underserved communities. Although support for community health centers will prevent millions of patients from losing access to primary care, the funding will unfortunately remain subject to the Hyde Amendment—a harmful provision that undermines women's health. I am deeply troubled with the continuation of this public law.

I am also troubled by the precedent set in this bill where we will begin charging some seniors more for their premiums. Medicare, like Social Security, is an earned benefit paid for over a lifetime.

Despite these serious objections, I will support this bipartisan legislation. Congress must preserve access to primary care for vulnerable individuals

and bring long sought stability to Medicare for our seniors. I urge my colleagues to join me in supporting this comprehensive legislation and permanently fix the SGR.

Mr. BOUSTANY. Mr. Speaker, this week the House has an opportunity to make historic reforms to Medicare that will provide certainty to doctors and patients across the country.

I spent 30 years practicing as a heart surgeon, fighting to save lives on the operating table every day.

I know firsthand that the cycle of temporary patches and extensions injects tremendous uncertainty into the process, making it much more difficult to run a successful practice.

Last week, I stood with a bipartisan group of Representatives and Senators to introduce the replacement legislation under consideration.

This bill repeals the unworkable SGR, consolidates duplicative programs, and improves transparency for patients and doctors. It is a historic solution to a problem that has plagued doctors and providers for over a decade.

But no solution is one hundred percent perfect.

I believe we must continue working toward full repeal of the unworkable Medicare outpatient therapy cap, something I've introduced legislation to address and will continue to work with my colleagues to make this law.

That's something I'll continue to fight for.

But today, it's time for Congress to do what we are elected to do: come together, find common ground, and pass a solution.

This is the first meaningful opportunity to fix this broken system in years—let's not bypass this moment.

I encourage all of my colleagues to support this permanent doc fix.

Mr. LANGEVIN. Mr. Speaker, I rise today in support of the Medicare Access and CHIP Reauthorization Act, which repeals once and for all the flawed Medicare physician reimbursement formula, known as the SGR, and replaces it with a payment system based on quality of care, value and accountability.

Since 2003, Congress has spent nearly $170 billion on short-term patches to temporarily avoid cuts under the SGR. This bipartisan, bicameral agreement will finally stabilize payments for medical providers and remove the persistent threat of rate cuts that have jeopardized access to care for our seniors.

Also contained in this legislation is a crucial two-year extension of the Children's Health Insurance Program. Although I would have preferred to see CHIP extended for four years, this measure allows us to take immediate action instead of waiting until the program expires in September, providing certainty to states like Rhode Island that are preparing their budgets for next year, while ensuring that over eight million children continue receiving the health coverage they need at increased funding levels set forth under the Affordable Care Act.

I am also pleased to see the inclusion of over $7 billion for community health centers that provide front line care to millions of families across the country, as well as $620 million for the National Health Service Corps and $120 million for Teaching Health Centers.

Of course, this legislation is not perfect. It includes provisions I do not support, such as reforms to Medigap deductibles for new Medicare beneficiaries beginning in 2020. However, this measure seeks to protect our most vulnerable citizens by permanently extending the Qualifying Individual (QI) program that helps low-income seniors pay their Medicare Part B premiums, and the Transitional Medical Assistance (TMA) program that assists families on Medicaid maintain their coverage for one year as they transition from welfare to work.

Mr. Speaker, this legislation will end the decade-long cycle of annual SGR patches, restore certainty Medicare providers, and extend vital health care programs our constituents depend on. I am pleased that members on both sides of the aisle have come together to address this issue, and I urge my colleagues to support this legislation and provide continued health security for our seniors, children and families

Mr. FLORES. Mr. Speaker, I rise in support of H.R. 2, the Medicare Access and CHIP Reauthorization Act.

I came to Congress because Washington was in the midst of a culture of excess—excessive spending, excessive regulation and excessive government.

Today, we have the opportunity to repeal and replace Medicare's SGR, an outdated reimbursement system that for over a decade Congress has passed patch after patch to fix the flawed formula while hiding the true state of Medicare.

Mr. Speaker, this legislation will take crucial steps to change spending and improve health care for America.

Today, we are voting to enact policy and reforms that generate savings and finally incentivize quality of care over quantity.

I urge my colleagues to support H.R. 2.

Mr. VAN HOLLEN. Mr. Speaker, I rise today in support of H.R. 2, Medicare Access and CHIP Reauthorization Act. This bill is not perfect but on its whole, it extends critical funding to ensure that kids in the Children's Health Insurance Program (CHIP) don't lose access to health insurance and to keep community health centers open to serve hardworking American families. It funds the successful Home Visiting Program, makes permanent a program to assist low-income seniors afford their Medicare premiums, and supports families on Medicaid who are transitioning to work. On top of preventing massive cuts to these programs, the legislation replaces a flawed payment system that wasn't working for people in Medicare, their physicians, or taxpayers.

In some areas—specifically in extending funding for CHIP for two years—I don't think the bill goes far enough. As a longtime supporter of CHIP, I advocated to extend funding for four years and included a four-year extension in the budget I offered in the House. House Democratic leadership fought for a four-year extension but was met with resistance from Republicans who have made quite clear that they would rather roll back coverage for kids in CHIP. Despite the two-year compromise, I'm pleased that the legislation funds CHIP at current levels and maintains the safeguards we set in the Affordable Care Act (ACA) to ensure coverage for every eligible child in the nation. Failure to pass this bill and fund CHIP would cause millions of kids to become uninsured or lose access to services, or would cause their parents to face higher out-of-pocket costs.

The bill also includes two years of additional funding for community health centers which provide primary care to families, seniors, people with disabilities, and veterans in Maryland and across the nation. Health centers keep people healthy and working by responding to the unique needs of their communities, create good-paying jobs, and train the next generation of the health care workforce. Without this bill, funding for health centers would be cut by 70 percent and over 7 million Americans could be at risk of losing critical health services. Not funding very cost-effective health providers is irresponsible and unfair to hardworking American families.

It comes as no surprise that my Republican colleagues would have liked to hijack this bill for their arsenal in their unending assault on women's health. If you need any evidence, just look at what Republicans did in the Senate trying to use the human trafficking bill to expand the Hyde amendment to permanent funds and non-taxpayer funds. I applaud the Democratic Senators blocking that Republican anti-choice effort. Let me be clear; this bill does not do that. I worked with Leader PELOSI and the co-chairs of the House Pro-Choice Caucus, of which I am a member, to counter attempts to codify the Hyde amendment. As a result, this bill continues the current policy for funding for community health centers. Just like the Hyde language included in annual appropriations bills, the provision is limited to taxpayer funds and temporary—terminating when the funding expires in 2017. I strongly share the ongoing concerns of the reproductive health community and I remain deeply committed to protecting a woman's fundamental right to choose her health care.

Finally, the bill repeals and replaces a deeply flawed physician payment system for paying physicians that basically penalizes doctors for participating in Medicare. For more than ten years, doctors have faced the threat of steep rate cuts required by a mindless formula in the law. Congress has repeatedly adopted short-term patches to prevent these cuts from taking effect. This crisis-driven approach to paying physicians makes it difficult for doctors to participate in Medicare, which ultimately is unfair to their patients—the seniors and disabled workers who rely on Medicare for access to the health care services they need. The bill rights this wrong with a smarter physician payment system that improves quality of care for people with Medicare.

Mr. Speaker, today's bill is not perfect but Congress must move forward with this bipartisan agreement to protect the health of America's families, children and seniors. I urge support H.R. 2.

Mr. LYNCH. Mr. Speaker, I rise today in support of the Medicare and CHIP Reauthorization Act, H.R. 2.

I commend Energy and Commerce Chairman FRED UPTON and ranking member FRANK PALLONE as well as Ways and Means Chairman PAUL RYAN and ranking member SANDER LEVIN for their hard work in putting this bill together.

The sustainable growth rate (SGR) was part of the Balanced Budget Act of 1997 but has proven to be far less than sustainable.

In fact, according to the Congressional Research Service, since 2003 Congress passed 17 laws overriding the SGR-mandated reductions in the Medicare physician fee schedule.

This bill may not be perfect but it seems to strike enough compromises that many of us are willing to support a good bill rather than hold out for a perfect one.

I am particularly pleased that the bill includes a two year extension of the Health Center Fund, which will provide an additional $3.6 billion per year to the nation's community health centers.

Created under the Affordable Care Act to expand the health centers program and increase access to care, the fund is set to expire after 2015.

Should it expire, health centers would be facing a 70% cut in funding which would force devastating reductions and closures at many of the more than 9,000 health centers nationwide.

We simply cannot allow that to happen.

Community health centers are critical to the health care equation, meeting the needs of approximately 23 million people every year. They provide access to primary and preventative health services that keep patients from seeking or eventually needing more costly care. And that benefits all of us.

The 1,300 federally funded health centers are located in every corner of our country and are distributed evenly between urban and rural areas. I am fortunate in my own district to have 7 community health centers treating more than one hundred thousand patients every year. In fact, as we recognize the 50th anniversary of our health centers, I am proud to acknowledge that the first community health center in the United States, Geiger Gibson, is located in my district.

Health centers serve all our constituents, Democrat and Republican, young and old, black, white or brown. they are vital to all our communities, and that is why this program has strong bipartisan support.

Whether you supported the Affordable Care Act or not, I think we all can agree that access to affordable health care helps to keep health costs down. Our community health centers provide that access. They are doing a terrific job for people across the nation.

That is why I strongly support our health centers and I urge my colleagues to join me in supporting this bill.

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to House Resolution 173, the previous question is ordered on the bill, as amended.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. BRADY of Texas. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, this 15-minute vote on passage of the bill will be followed by a 5-minute vote on agreeing to the Speaker's approval of the Journal, if ordered.

The vote was taken by electronic device, and there were—yeas 392, nays 37, not voting 4, as follows:

[Roll No. 144]

YEAS—392

Abraham
Adams
Aderholt
Aguilar
Allen
Amodei
Ashford
Babin
Barletta
Barr
Barton
Bass
Beatty
Becerra
Benishek
Bera
Beyer
Bilirakis
Bishop (GA)
Bishop (MI)
Bishop (UT)
Black
Blackburn
Blumenauer
Boehner
Bonamici
Bost
Boustany
Boyle, Brendan F.
Brady (PA)
Brady (TX)
Brooks (IN)
Brown (FL)
Brownley (CA)
Buchanan
Bucshon
Burgess
Bustos
Butterfield
Byrne
Calvert
Capps
Capuano
Cárdenas
Carney
Carson (IN)
Carter (GA)
Carter (TX)
Cartwright
Castor (FL)
Castro (TX)
Chabot
Chaffetz
Chu, Judy
Cicilline
Clark (MA)
Clarke (NY)
Clawson (FL)
Clay
Cleaver
Clyburn
Coffman
Cohen
Cole
Collins (GA)
Collins (NY)
Comstock
Conaway
Connolly
Conyers
Cook
Costa
Costello (PA)
Courtney
Cramer
Crawford
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Curbelo (FL)
Davis (CA)
Davis, Danny
Davis, Rodney
DeFazio
DeGette
Delaney
DeLauro
DelBene
Denham
Dent
DeSaulnier
Deutch
Diaz-Balart
Dingell
Doggett
Dold
Doyle, Michael F.
Duckworth
Duffy
Duncan (SC)
Duncan (TN)
Edwards
Ellison
Ellmers (NC)
Emmer (MN)
Engel
Eshoo
Esty
Farenthold
Farr
Fattah
Fincher
Fitzpatrick
Fleischmann
Fleming
Flores
Forbes
Fortenberry
Foster
Foxx
Frankel (FL)
Franks (AZ)
Frelinghuysen
Fudge
Gabbard
Gallego
Garamendi
Gibbs
Gibson
Goodlatte
Gosar
Gowdy
Graham
Granger
Graves (LA)
Graves (MO)
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Guinta
Guthrie
Gutiérrez
Hahn
Hanna
Hardy
Harper
Harris
Hartzler
Hastings
Heck (NV)
Heck (WA)
Hensarling
Herrera Beutler
Hice, Jody B.
Higgins
Hill
Himes
Holding
Honda
Hoyer
Hudson
Huffman
Huizenga (MI)
Hunter
Hurd (TX)
Hurt (VA)
Israel
Jackson Lee
Jeffries
Jenkins (KS)
Jenkins (WV)
Johnson (GA)
Johnson (OH)
Johnson, E. B.
Joyce
Kaptur
Katko
Keating
Kelly (IL)
Kelly (PA)
Kennedy
Kildee
Kilmer
Kind
King (NY)
Kinzinger (IL)
Kirkpatrick
Kline
Knight
Kuster
LaMalfa
Lamborn
Lance
Langevin
Larsen (WA)
Larson (CT)
Latta
Lawrence
Lee
Levin
Lewis
Lieu, Ted
Lipinski
LoBiondo
Loebsack
Lofgren
Long
Love
Lowenthal
Lowey
Lucas
Luetkemeyer
Lujan Grisham (NM)
Luján, Ben Ray (NM)
Lynch
MacArthur
Maloney, Carolyn
Maloney, Sean
Marino
Matsui
McCarthy
McCaul
McCollum
McDermott
McGovern
McHenry
McKinley
McMorris Rodgers
McNerney
McSally
Meehan
Meeks
Meng
Messer
Mica
Miller (FL)
Miller (MI)
Moolenaar
Mooney (WV)
Moore
Moulton
Mullin
Murphy (FL)
Murphy (PA)
Napolitano
Neal
Neugebauer
Newhouse
Noem
Nolan
Norcross
Nugent
Nunes
O'Rourke
Olson
Palazzo
Pallone
Pascrell
Paulsen
Pearce
Pelosi
Perlmutter
Perry
Peters
Peterson
Pingree
Pittenger
Pitts
Pocan
Poe (TX)
Poliquin
Polis
Pompeo
Posey
Price (NC)
Price, Tom
Quigley
Rangel
Reed
Reichert
Renacci
Ribble
Rice (NY)
Rice (SC)
Richmond
Rigell
Roby
Roe (TN)
Rogers (AL)
Rogers (KY)
Rohrabacher
Rokita
Rooney (FL)
Ros-Lehtinen
Roskam
Ross
Rothfus
Rouzer
Roybal-Allard
Royce
Ruppersberger
Rush
Russell
Ryan (OH)
Ryan (WI)
Salmon
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Scalise
Schiff
Schock
Schrader
Scott (VA)
Scott, Austin
Scott, David
Serrano
Sessions
Sewell (AL)
Sherman
Shimkus
Shuster
Simpson
Sinema
Sires
Slaughter
Smith (MO)
Smith (NE)
Smith (NJ)
Smith (TX)
Speier
Stefanik
Stewart
Stivers
Stutzman
Swalwell (CA)
Takai
Takano
Thompson (CA)
Thompson (MS)
Thompson (PA)
Thornberry
Tiberi
Tipton
Titus
Tonko
Torres
Trott
Tsongas
Turner
Upton
Valadao
Van Hollen
Vargas
Veasey
Vela
Velázquez
Wagner
Walberg
Walden
Walker
Walorski
Walters, Mimi
Walz
Wasserman Schultz
Waters, Maxine
Watson Coleman
Weber (TX)
Webster (FL)
Welch
Wenstrup
Westerman
Westmoreland
Whitfield
Williams
Wilson (FL)
Wilson (SC)
Wittman
Womack
Woodall
Yarmuth
Yoder
Yoho
Young (AK)
Young (IA)
Young (IN)
Zeldin
Zinke

NAYS—37

Amash
Blum
Brat
Bridenstine
Brooks (AL)
Buck
Cooper
DeSantis
DesJarlais
Garrett
Gohmert
Graves (GA)
Grothman
Huelskamp
Hultgren
Issa
Johnson, Sam
Jolly
Jones
Jordan
King (IA)
Labrador
Loudermilk
Lummis
Marchant
Massie
McClintock
Meadows
Mulvaney
Nadler
Palmer
Ratcliffe
Sanford
Schakowsky
Schweikert
Sensenbrenner
Visclosky

NOT VOTING—4

Hinojosa
Payne
Ruiz
Smith (WA)

□ 1207

Messrs. MULVANEY and SCHWEIKERT changed their vote from ''yea'' to ''nay.''

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

THE JOURNAL

The SPEAKER pro tempore. The unfinished business is the question on agreeing to the Speaker's approval of the Journal, which the Chair will put de novo.

The question is on the Speaker's approval of the Journal.

Pursuant to clause 1, rule I, the Journal stands approved.

□ 1215

THE MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT

(Mr. THOMPSON of Pennsylvania asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. THOMPSON of Pennsylvania. Mr. Speaker, moments ago, the House